Protecting Child Safety and Health in Indiana's Child Care Programs:

Recommendations for how to streamline and standardize Indiana's child care licensing requirements across the state's early care and education programs

FINAL REPORT

Indiana Early Learning Advisory Committee

Submitted by

POLICY EQUITY GROUP

Advancing the Potential of Early Childhood

April 30, 2024

Table of Contents

Introduction

Indiana's child care licensing regulations define the health and safety requirements necessary for a child care program to legally operate. These regulations, which range from requiring criminal background checks to procedures on discipline and safe sleep, are the primary way to provide a reasonable assurance of the safety of child care programs. The breadth, content, clarity, and quality of the regulations, as well as how they are monitored and enforced, impact the state's ability to mitigate risk and prevent harm to children in child care. Licensing violations, which are published on Indiana's Care Finder website, also provide important information to parents as they consider different care options.

At the same time, child care regulations can impact the cost and supply of child care. Additional licensing requirements can mean a greater cost to child care businesses and more expensive child care for families. Accordingly, these regulations must protect the health and safety of children while considering the broader impact on child care businesses, families, and the overall child care system.

Currently, Indiana's child care providers face a complex, confusing, and often duplicative regulatory environment.[1] There are seven sections of Indiana Code that define the requirements of child care providers to legally operate, eight administrative rule sets that have been promulgated based on the Indiana Code, and eight interpretive guideline documents that provide rationale and act as a tool for determining compliance. Licensing rules vary dramatically by provider type (e.g., child care centers as compared to child care ministries) and often do not align with or are duplicative of other regulations and early childhood initiatives such as Paths to QUALITY™ (PTQ™) or On My Way Pre-K.

In March of 2022, Indiana's Office of Early Childhood and Out-of-School Learning (OECOSL) began a review of the state's child care regulations in connection with Indiana's Licensing Workgroup, which was convened for this purpose. The effort resulted in several immediate improvements to the regulatory environment that supported the operational sustainability of providers, as well as better licensing practices and enforcement.

In 2023, the Indiana legislature issued a charge to the state's Early Learning Advisory Committee (ELAC) to conduct a third-party assessment of existing regulations and to provide recommendations no later than July 1, 2024. In 2024, Senate Enrolled Act 2 moved up the deadline for the recommendations to May 1, 2024, providing a strong indication from the legislature of urgent need for child care licensing reform. The legislative charge instructed that the recommendations:

(A) maintain health and safety standards;

(B) streamline administrative burdens, program standards, and reporting requirements for child care providers;

(C) provide flexibility for a child care provider with a Level 3 or Level 4 PTQ™ program rating to expand to other locations; and,

(D) assist accredited kindergarten through grade 12 institutions in establishing and providing high quality onsite child care and early learning programs.

[1] Indiana Office of Early Childhood & Out-of-School Learning. (2024). *Summary of efforts to support regulatory planning and updates.*

Methodology

To develop the recommendations, three sources of information were reviewed and analyzed. The goal of the methodological approach was to derive a balanced set of recommendations based on the latest research, best practice in state child care licensing, and the work that has been conducted by the state to date. The methodology included:

Literature and document review. Both within Indiana and nationally, numerous stakeholder groups, organizations, and administrative entities have expended considerable effort examining how best to revise and improve child care regulations. Within Indiana, the work done by OECOSL since 2022 has yielded several reports, and Indiana providers and provider groups, including the Indiana Afterschool Network, have written memoranda and other documents outlining specific regulatory burdens and offering recommendations.

In addition, the National Association of Regulatory Agencies (NARA), Child Care Aware® of America, and the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services have numerous resources for states in developing child care regulations. Most notably, ACF's *Caring for Our Children Basics* document provides guidance to states on minimum health and safety standards that reduce redundancy and promote child health and well-being.

Stakeholder interviews and focus groups. To obtain the perspectives of those who will be most directly affected by the child care licensing revisions, virtual interviews and focus groups were conducted with licensing consultants, child care providers, and representatives from the out-of-school time community. Interview questions focused on respondents' current experience with the licensing requirements and their concerns and recommendations related to the requirements. In addition, ELAC staff also conducted regional stakeholder meetings across Indiana to solicit stakeholder feedback. Finally, the ELAC and other key stakeholder groups were briefed throughout the process on the recommendations. These groups provided important feedback that informed the work. More information on the stakeholders who provided input is available in Appendix A.

Standards review. Finally, for each regulatory set, a standard-by-standard review was conducted. Through this process, the current regulations were sorted into licensing categories developed by NARA, including behavior and guidance, food preparation, safety, and others. This step made it easier to identify overlapping or redundant regulations within each regulatory set. Next, each standard was analyzed to determine if it focused on child health and safety or quality and sorted into one of the two categories. If a standard was determined to have the goal of protecting child health and safety, it was further analyzed to determine the necessity and age appropriateness of the regulation and the amount of burden it created for child care programs. In addition, the regulation was assessed to determine whether it was required by federal regulation, its level of alignment to OECOSL's licensing workgroup recommendations, and the extent to which it reflected the latest research and best practice.

Below, the report recommendations are presented in two ways. The next section outlines recommendations for each regulatory category and includes: (1) a brief introduction outlining why the regulatory category is important; (2) the specific recommendations for that category; and (3) the rationale behind the recommendations.

Next, a core set of licensing regulations for all Indiana child care programs is provided. Building off the OECOSL licensing workgroup recommendation that Indiana create one "small but powerful" list of core basic health and safety standards that apply to all programs, this section operationalizes that recommendation. The section provides a core set of standards that could apply to all programs based on the recommendations of the first section.

Both the category-specific recommendations and core set of regulations are designed to meet the legislative charge and support the state in the promulgation of new regulations.

Overview of the recommendations

The recommendations build on the Indiana licensing workgroup report.[2] They work to significantly streamline the current regulations and create more consistency in the requirements across Indiana's different child care programs. Specifically, the recommendations work to:

- **Create one set of regulations that apply to all settings** with limited distinctions by number of children served and the type of setting/structure (residential or non-residential) where children are being cared for.
- **Streamline the regulations by focusing on health and safety standards** and removing standards related to quality that are addressed in the proposed revisions of the PTQ™ system.[3]
- **Generally maintain current ratio and group sizes,** with some modifications to create consistency and offer flexibility.
- **Establish a more direct measure of staff qualifications** that is consistent across roles and program types to better ensure that all caregivers are qualified with essential health and safety, classroom management, and child development competencies and skills.
- **Provide more flexibility in facilities,** creating a standard path and an opportunity to submit an alternative plan that meets the intention of the applicable regulation.

[2] Office of Early Childhood & Out-of-School Learning. (January 2024). *Summary of Efforts to Support Regulatory Planning and Updates.* Prepared by Mapt Solutions.

[3] Indiana Early Learning Advisory Committee and Policy Equity Group (December 2023). *Implementing a Revised Paths to QUALITY™ Program: Recommendations for how to define, measure, support and reward quality in Indiana's early care and education settings. https://www.in.gov/fssa/carefinder/files/ELAC-Report_12-2023.pdf*

Personnel, Ratios and Grouping, and Supervision

Background Screening
Medical and Drug Screening
Personnel Qualifications
Training – Initial and Ongoing
Ratio, Group Size, Grouping, and Personal Space
Supervision

Regulatory Area:
Background Screening

Comprehensive background screenings identify individuals with a criminal history who may cause harm to a child's mental or physical well-being. Background checks are required by federal law for programs receiving federal child care assistance and must include:

- A national FBI criminal history check using fingerprints
- A search of the National Crime Information Center's National Sex Offender Registry
- A search of Indiana registries and databases and the registries and databases in each state where the staff member has lived in the past 5 years, including:
    - State criminal registry or repository (fingerprints are required in the state where the staff member currently lives and are optional in other states)
    - State sex offender registry or repository
    - State-based child abuse and neglect registry and database

This process to protect the safety of young children slows the recruiting and hiring of early educators. The dearth of locations for FBI fingerprint checks in Indiana was cited by stakeholders as a barrier to fulfilling this licensing requirement.

The recommendations seek to standardize requirements across the regulator sets and simplify the background check process, building on recommendations of the licensing workgroup.

Recommendations

1. Make background check policies and procedures consistent by applying the current regulatory code for voucher programs to all early learning programs.
2. Continue temporary, provisional employment (with supervision) and allow voucher payments while individuals providing care wait for the national criminal history background check if they have submitted their fingerprints and there were no findings from a local criminal history check.[4]

Rationale

This recommendation requires all programs to meet national standards of best practice and federal requirements.[5] Implementing this recommendation ensures that even if a program does not accept Child Care and Development Fund (CCDF) vouchers, they would comply if they later decided to pursue participation in the voucher program.[6]

The recommendation to maintain provisional employment (with supervision) acknowledges the staffing challenges presented by background screens, particularly the length of time it takes to complete the FBI fingerprint screen, and how it contributes to the ongoing early childhood workforce crisis. Provisional employment minimizes this obstacle. This recommendation is consistent with the work done to address challenges with the background check process. In January, OECOSL shared it has successfully created a support process for portable background checks.[7]

---

[4] Findings that would prohibit provisional employment are described in the Indiana statute about background checks for programs receiving the federal voucher.

[5] Early Childhood Learning & Knowledge Center. (2022). *Caring for Our Children Basics*: Background Screening. U.S. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/background-screening

[6] Indiana State Government. (2019). Child Care and Development Fund Drug Testing Guidelines. https://www.in.gov/fssa/carefinder/files/Drug-Testing-Guidelines.pdf

[7] Indiana Office of Early Childhood & Out-of-School Learning. (2024). Summary of efforts to support regulatory planning and updates.

Regulatory Area:

Personnel – Medical and Drug Screening

Medical examinations ensure incoming staff do not expose children to communicable diseases such as tuberculosis and that staff can physically fulfill their roles. To ensure staff can supervise children and respond to emergencies, drug tests at the start of employment complement program policies prohibiting drug use.

Recommendations

1. Upon employment, any staff member who has direct contact with children should provide documentation of:
    a. A physical examination by a physician or nurse practitioner that states there is no known communicable disease in an infectious state and no physical or mental conditions that would interfere with assigned child care duties.
    b. Tuberculosis screening through a Mantoux tuberculin or Interferon Gamma Release Assay (IGRA) test. Persons with a history of tuberculosis or a positive Mantoux or IGRA test must have an annual health assessment, including a symptom screening for tuberculosis documented by a health professional. For care provided in residential settings, this testing applies to all household members over eighteen (18) years of age.
2. Prior to employment, drug testing is required of caregivers and any individuals over age 18 residing at a site where child care is provided.

Rationale

Physical exam requirements, including tuberculosis testing, are a common health and safety practice in most states.[8] This practice ensures individuals working with children can respond to safety incidents and do not have communicable diseases that could spread to children.

Caring for Our Children standards on background screening state that drug tests and screens may be part of the background screening.[9] Indiana Code for homes, centers, and vouchers require drug testing of individuals working with young children. Implementing this recommendation for all programs ensures that even if a program does not currently accept the voucher, they would comply with Indiana regulations if they later decided they wanted to pursue participation in the voucher program.[10]

---

[8] Child Care State Capacity Building Center. (2023). *Child care workforce qualifications, training, and professional development resource guide.* US Health and Human Services, Administration for Children and Families. https://childcareta.acf.hhs.gov/sites/default/files/new-occ/resource/files/Resource%20Guide_ChildCareWorkforce.pdf

[9] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children, Chapter 1: Staffing, 1.2 recruitment and background screening.* https://nrckids.org/CFOC/Database/1.2.0.2

[10] Indiana State Government. (2019). *Child Care and Development Fund Drug testing guidelines.* https://www.in.gov/fssa/carefinder/files/Drug-Testing-Guidelines.pdf

Regulatory Area:

Personnel Qualifications

Personnel qualifications define the minimum education credentials and competencies necessary for an individual to work in a child care program. Along with background checks and health and safety trainings, these qualifications ensure that individuals working in a child care program pose no harm to children and possess the knowledge and skills necessary to keep children safe and healthy during a normal day, as well as when there is an emergency. Individuals working in child care programs must be able to engage in important tasks that require certain competencies, including administering medication, following emergency procedures, reading labels, and communicating with families.

Recommendations

1. Significantly streamline and specifically target the most important personnel qualifications by defining minimum qualifications by two criteria:
    a. High-school degree or equivalent, and
    b. Passing an assessment that determines whether an individual has the competencies necessary to successfully fulfill a specific role within a child care program.

These two criteria should be used for all child care programs and all roles within a program. To determine what specific competencies to address for each role, the state should draw from the competencies found in Indiana Core Knowledge and Competencies for Early Childhood, School-Age, and Youth Professionals. Each assessment should be specifically designed to assess the competencies necessary for each specific role (see below) and should incorporate simulated or real performance tasks to demonstrate skill. It will also be important to ensure that these qualifications align with the state's work-based learning and apprenticeship initiatives. New regulations should consider and accommodate students pursuing work-based learning, apprenticeships, and other experiences to align with Indiana's new high school initiatives, including the Indiana Graduates Prepared to Succeed (GPS) program.

2. For the purposes of determining personnel qualifications, collapse and rename the current role categories within a program to: Director, Qualified Caregiver, and Substitute.

Rationale

The first personnel qualification criteria—a high-school diploma or equivalent—recognizes that an individual should have a basic level of education to complete tasks related to health and safety within a child care program. At the same time, a high-school degree or equivalent does not necessarily equate to an individual having the competencies necessary to address real-world health and safety situations. Accordingly, it is also important to include a second criteria—an assessment of competencies necessary to work in a child care program.

There is precedent for this assessment approach. States like Maine and Maryland currently require child care providers and educators in licensed settings to pass an assessment to demonstrate competency on health and safety topics following training. Indiana can become a leader in this area by creating the first licensing assessments that capture comprehensive child educator competencies (e.g., child development, health, and safety). Recognizing that different roles require different competencies, assessments could be tailored to the specific role within a program (Director, Qualified Caregiver, etc.). For example, child care directors require competencies that would differ from a lead teacher, and therefore the assessment would align with the competencies specific to that role. Indiana can also explore different types of assessments to

determine which provides the most accurate measure of competencies with the least amount of administrative burden and cost.

This approach aligns to the Indiana licensing workgroup report, which recommends that practitioners without degrees and with limited access to college have an alternative pathway to obtain knowledge.[11] Using the assessment approach, child care workers would be deemed qualified not on whether they have obtained a degree, but on a direct measure of the actual knowledge and competencies they demonstrate through whatever pathway was used to obtain the necessary knowledge and skills.

In addition, the Indiana licensing workgroup recommended a change in the culture of the licensing process from "finding violations to finding solutions" and that the state should "encourage continuous quality improvement."[12] From the assessment scores, the state would have additional information on the strengths, weaknesses, and knowledge gaps of each individual working in a child care program on which to base a continuous quality improvement process.

The licensing workgroup also recommended that high school graduates (18 years of age or older) be allowed to work unsupervised as classroom teachers in child care centers, as long as they have completed the required pre-service training and background checks. The assessment would provide additional evidence that an individual, regardless of age, had the competencies to work alone in a program.

The recommendation also is consistent with federal CCDF regulations that require states to detail the required qualifications for caregivers in child care programs but do not specify what those qualifications should be. At the same time, CCDF regulations do require that personnel qualifications "… promote the social, emotional, physical, and cognitive development of children and improve the knowledge and skills of caregivers, teachers, and directors in working with children and their families…." Accordingly, individuals working in child care programs should receive training in this area and the assessment of competencies will need to incorporate the ability of individuals within a child care program to support the different developmental domains of the children in their care.

Finally, the recommendations address stakeholder feedback that it is difficult to find staff with the credentials required under the current regulations. The shift from a credential-based to a competency-based approach should support stakeholders in finding staff that are competent in working in a child care program but may not have the credential currently required.

[11] Stoney, L., & McGowan, H. (2023). *Indiana Licensing Work Group summary report.* Opportunities Exchange.

[12] Ibid.

Regulatory Area:

Personnel – Training

Early childhood program staff must be properly equipped to safeguard the health and safety of young children. Pre-service and in-service training equips staff with basic health and safety knowledge and protocols, and prepares them to manage health and safety situations as they arise.

Recommendations

1. All staff members employed by a program should have the following training requirements within the timeframes indicated. The program should keep documentation showing that all applicable training topics are covered and the dates of when the training was provided to staff within the last calendar year:
    a. Pre-service and annual training (once every calendar year) that includes:
        - Developmentally appropriate practices to implement positive discipline and support cognitive and social emotional development;
        - Parent communication strategies;
        - Recognizing symptoms of illness;
        - Cleaning, sanitation, and disinfection procedures;
        - Safe sleep practices;
        - Staff occupational health and safety practices, (i.e., Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations);
        - Procedures for an emergency and disaster preparedness;
        - Response procedures should a child be injured;
        - Child abuse detection, prevention, and reporting responsibilities; and
        - Basic first aid.
    b. Orientation training should occur within the first 90 days a staff member begins their employment and include:
        - Food safety and handling;
        - Daily schedules, routines, and transition procedures;
        - Special needs inclusion policies;
        - Training specific to the developmental period of children under their care (e.g., infants and toddlers); and
        - The program's confidentiality policy.
2. At least one staff member trained and certified in CPR should be present at the program any time children are present.

Rationale

The health and safety situations that a program may encounter do not change depending upon the type of early learning program. For example, training on preventing child abuse and neglect and conducting CPR are important to the safety of children in all programs. Therefore, ensuring all caregivers are properly prepared with both pre-service and in-service training is paramount. Further, the federal Child Care and Development Fund requires that states outline how staff will be trained to keep children physically safe, including training on the following topics: infectious disease, safe sleeping practices, administering medication, allergic reactions, handling potential biocontaminants, CPR, and other minimum health and safety requirements.[13]

The recommendations about required training are informed by national standards of best practices provided by Caring for Our Children and are aligned with different sets of current Indiana Administrative Code. The recommendations apply consistency across all early childhood programs.

[13] United States Code. (1990). *Title 42—The Public Health and Welfare, Chapter 105—Community Services Programs, Child Care and Development Block Grant Act of 1990.* https://uscode.house.gov/view.xhtml;jsessionid=8B813EDF705832742FCA36A1564826A5?req=granuleid%3AUSC-prelim-title42-chapter105-subchapterII-B&saved=%7CKHRpdGxlOjQyIHNlY3Rpb246OTg1OCBlZGl0aW9uOnByZWxpbSkgT1lgKGdyYW51bGVpZDpVU0MtcHJlbGltLXRpdGxlNDItc2VjdGlvbjk4NTgp%7CdHJlZXNvcnQ%3D%7C%7C0%7Cfalse%7Cprelim&edition=prelim

Regulatory Area:

Group Size, Ratios, Grouping, and Personal Space

Regulations related to group size, adult-to-child ratios, and groupings ensure appropriate levels of supervision and support to protect the safety and well-being of children in a child care program.[14] Ratios and group sizes are lower for younger children to account for the higher level of supervision and support necessary to keep them safe. Regulations related to physical space per child prevent overcrowding that can lead to injury and the spread of illnesses, while allowing adequate space for children to explore and learn.

Recommendations

1. Create consistent adult-to-child ratio and grouping requirements across settings by:
    a. Having consistent age delineations that define ratios, group sizes, and groupings in sites with more than 16 children with single-age classrooms. These age delineations should be:
        - 0-12 months ("infant" or "less than one-year-old")
        - 13-23 months (one-year-old)
        - 24-35 months (two-year-old)
        - 36-47 months (three-year-old)
        - 48-59 months (four-year-old)
        - 60 months (five-years-old or older)
    b. Creating two classes of sites based on size that adhere to the following ratios and group sizes:

Ratios

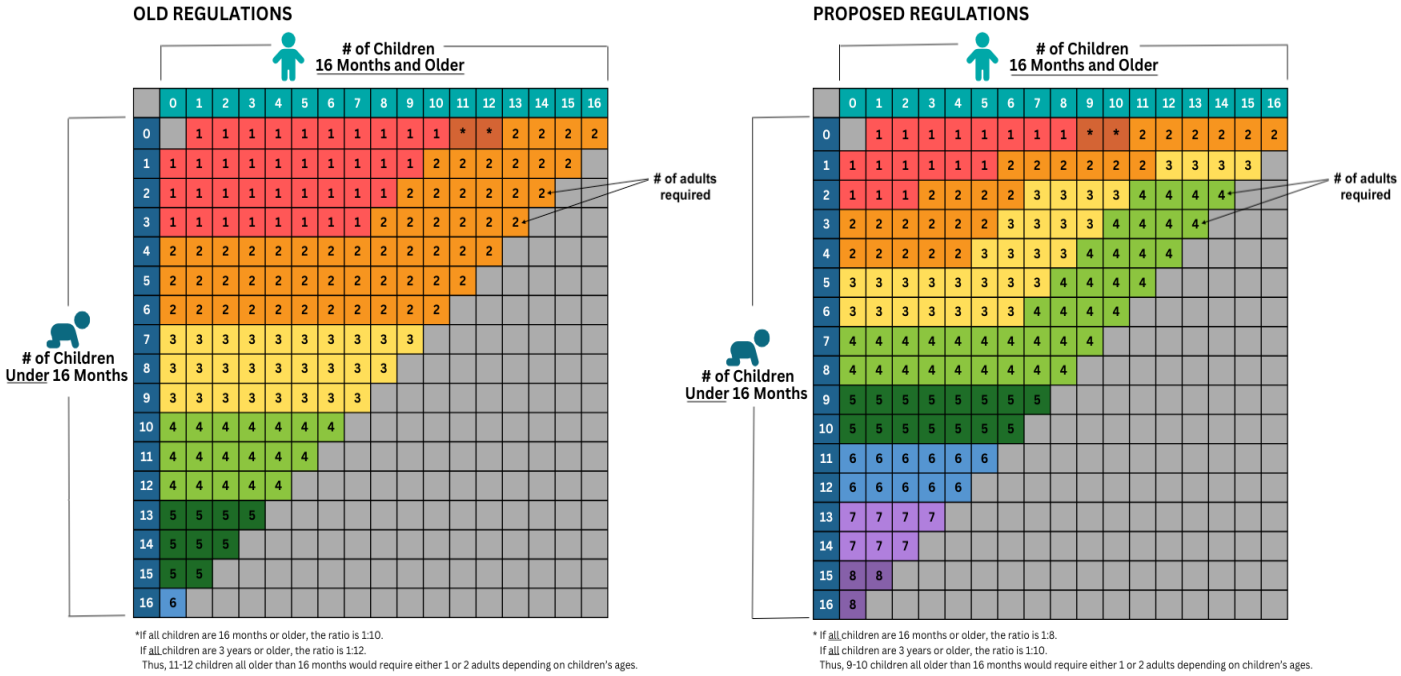
Sites with less than 16 children with mixed ages		Sites with more than 16 children with single-age classrooms	
Two children younger than 16 months per adult	1:4	0-12 months	1:4
One child younger than 16 months per adult	1:6	13-23 months	1:5
No children younger than 16 months	1:8	24-35 months	1:5
No children younger than 3	1:10	3-year-olds	1:10
		4-year-olds	1:12
		5-year-olds	1:15

For programs with less than 16 children, the number of children younger than 16 months is capped at two children per adult. This is to ensure that there are enough adults available to appropriately attend to children who may not be walking in case of an emergency.

In cases where a site with less than 16 children serves only one age group of children (e.g., three-year-olds) the site may choose to adhere to the single-aged ratios of larger sites. Similarly, larger sites with mixed-aged classrooms may choose to adhere to mixed-age ratios of smaller sites in individual classrooms.

[14] Miranda, B. (2017, June 15). *Higher child staff ratios threaten quality child care.* Child Trends. https://www.childtrends.org/publications/higher-child-staff-ratios-threaten-quality-child-care

Figure 1. Current and Proposed Adult-Child Ratio



The numbers in the grid are the number of adults required for the number of children. For example, in both old and proposed regulations, if you had 2 infants under 16 months and 2 children 16 months or older, you would be required to have 1 caregiver.

Figure 1 provides a comparison of the old and new ratios for programs caring for 16 children or less. The graphic provides the number of adults that would be required (within each square) based on the number of children in the program under the age of 16 months (far left column) and the number of children over 16 months (top row).

Group Size

Sites with less than 16 children with mixed ages		Sites with more than 16 children with single-age classrooms	
Two children younger than 16 months	16	0-12 months	8
One child younger than 16 months	16	13-23 months	10
No children younger than 16 months	16	24-35 months	10
No children younger than 3	16	3-year-olds	20
		4-year-olds	24
		5-year-olds	30

c. Adult-to-child ratios must always be maintained.
d. Consistent with current regulations, only adults who "are responsible for and directly engaged in supervising and implementing activities for children" should be counted in the ratio. Consistent language related to this definition of caregiver should be used across all programs.
e. All children in the program who require supervision by an adult, regardless of whether they are related to the caregiver, should be included in the ratio count of children.

2. Maintain current square footage requirements of 35 square feet of usable indoor space per child in the child care program, with 50 square feet of usable space for infants.
3. For sites that maintain single-age classrooms, support the continuity of care by allowing children who have a birthday during the program year to stay with their current age cohort until a new classroom can be assigned or August 1st of the program year, whichever comes first.
4. Remove the 13-month maximum age difference in mixed-age classrooms.

Rationale

While ratios and group size requirements vary significantly across Indiana's current regulatory sets, adequate supervision of children is not site dependent. Regardless of whether a child is supervised in a CLASS I Home or a child care center, as defined by current regulations, the level of supervision and support necessary to protect child health and safety is the same. The recommendations make changes to the state's current CLASS I and II home-based ratios, allowing the same number of children to be served in residential settings, but with a different configuration of ages that better protects the health and safety of the youngest children in the site. The center-based ratios stay the same, and proposed ratios work to balance appropriate levels of supervision with the need for programs to generate adequate revenue to sustain themselves as small businesses. The recommendations work to create more consistency across program types, focusing on program size and the ages of children cared for at the site. The recommendations provide flexibility for sites to determine whether they want to adhere to mixed-age or single-age group sizes and ratios.

In addition, the recommendations adhere to CCDF regulations that require states to describe group size limits and ratios of children, but do not specify a required ratio or group size.

The recommendations also address numerous aspects of Indiana's licensing workgroup report including: making the licensing regulations easier to follow; consolidating the number of rules and regulatory sets; revising and making consistent across programs the definition of infant (birth to 12 months); removing the 13-month maximum age difference in mixed-age classrooms; and allowing a child who has had a birthday to stay in his/her current classroom until a slot in a classroom of older children has opened up.

Finally, for children no longer using a crib, 35 square feet per child indoors is the typical requirement in most states for centers (42 states), family child care (23 out of 44 states), and group homes (28 out of 28 states).[15] Indiana currently requires 35 feet per child in programs, which is the recommended standard.

[15] See the Trends in Child Care Licensing Requirements for 2020 series. https://childcareta.acf.hhs.gov/resource/trends-child-care-licensing-requirements-2020

Regulatory Area:

Supervision

Supervision practices and policies support staff in being able to observe children to prevent injury.[16] These practices and policies work jointly with building and environment rules to provide a comprehensive approach to child safety. They also position staff to respond quickly and safely in the event of an injury or an emergency (e.g., the ability to carry all young children not yet able to walk during an evacuation).

Recommendations

1. All programs should require that children be directly supervised at all times.
    a. Programs have practices to ensure teachers do not have to leave children unsupervised and are able to actively supervise children (e.g., the program has ways to communicate with other caregivers or the director without leaving the children);
    b. For non-residential settings, there should be a minimum of two people during operating hours in case of emergency; and
    c. For night care staffing, two caregivers should be on duty at all times regardless of the child-staff ratio and must be awake at all times to be included in the ratio.
    d. During nap times, children are supervised and ratios are maintained for the site; however, caregivers may supervise children toddler age and above at fifty percent (50%) of the required child/staff ratio if fifty percent (50%) of the class is asleep and required caregivers are immediately accessible.
2. All programs should only allow staff to be unsupervised with children if the individual has:
    a. Cleared background check requirements. Any adult who has not completed the background check components must be supervised by someone who has had a qualifying background check result within the past five years.[17]
    b. Completed training in pediatric first aid and CPR, safe sleep practices, precautions to prevent communicable disease, poison prevention, shaken baby syndrome/ pediatric abusive head trauma. If not, they must be supervised until training is completed.[18]
3. All programs should identify an individual to serve as the point of contact for a child care site, with authority and knowledge to implement program protocols, meet with licensing representatives, respond to emergencies, and communicate with parents and staff on program operations. In most cases this would be a program director, though for multi-sites with one director, a staff member could be identified to take on these responsibilities at each site.
4. All programs must make a reasonable effort to support continuity of care and a primary caregiver should be assigned for each child.

---

[16] Early Childhood Learning & Knowledge Center. (2024). *Active supervision.* U.S. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/safety-practices/article/active-supervision

[17] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register*, 81(190), 67484, *Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67500). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

[18] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register*, 81(190), 67484, *Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67507). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

5. All programs should have policies on supervision during field tips, which include:
    a. Caregivers accounting for all children before, during, and after field trips; and
    b. The program obtaining written or digital parental permission for each child prior to participation in a field trip.

Rationale

Federal CCDF regulations and *Caring for Our Children Basics* emphasize the importance of supervision of children.[19] Recommendations include practices that support educators in being able to continually supervise children, such as ways for staff to communicate with other staff if they are in a situation where they need to leave children, thus preventing children from being unsupervised. Having two individuals on site when children are in non-residential care is important in case one caregiver is incapacitated (e.g., medical incident) or other emergencies arise.

The CCDF Final Rule describes supervision of provisional staff members who are waiting for completion of all background check components. The person supervising provisional staff must have received a qualifying background check result within the past five years. Additionally, any teacher or caregiver working directly with children "must be supervised until training is completed in pediatric first aid and CPR, safe sleep practices, standards precautions to prevent communicable disease, poison prevention, and shaken baby syndrome/abuse head trauma"[20] because of the critical importance of these trainings for protecting the health and safety of children in their care. Federal regulations also state that volunteers be supervised if they have not had a background check that complies with the statute.

Identifying a program point-of-contact is important to ensure there is a specific individual on-site who can quickly respond to emergencies, address immediate operational issues, and communicate with parents and with any licensing staff.

Continuity of care—keeping young children with the same caretaker for at least a year—provides many benefits for young children, including the development of secure attachments, which are important for child development.[21] Similarly, primary caregiving, when a child is assigned to one specific caregiver, also promotes healthy development in children.[22] These practices support health and safety. Young children are either not verbal or have limited vocabulary to express their needs. A primary caretaker is attuned to what is typical for an individual child and can more easily identify potential safety or health concerns. This also supports staff in being able to account for all children in an emergency.

Finally, while field trips are important learning opportunities, they pose safety and health risks such as opportunities for children to wander off, proximity to strangers, and a larger area for staff to supervise. Active supervision is critically important during field trips and staff should make sure all children are accounted for before, during, and after a field trip. Parents have a right to know about field trips that take children outside of the child care site and should be notified.

---

[19] *See Caring for Our Children Basics* 2.2.0.1

[20] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register*, 81(190), 67484, *Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67507). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

[21] Child Care State Capacity Building Center. (2020). Program for Infant/Toddler Care's six essential program practices for relationship-based care: *Continuity of care*. https://childcareta.acf.hhs.gov/sites/default/files/itrg_continuity_of_care_pitc_rationale.pdf

[22] Child Care Technical Assistance Network. (2020). *Primary caregiving.* https://childcareta.acf.hhs.gov/infant-toddler-resource-guide/pd-ta-professionals/relationship-based-care/primary-caregiving

Behavior and Guidance

Discipline and Guidance
Activities and Programming

Regulatory Area:

Behavior & Guidance – Discipline and Guidance

Inappropriate discipline, including corporal punishment, causes a child physical and/or emotional harm.[23] Prohibiting inappropriate discipline promotes the safety of young children while in a child care program.

Recommendations

1. Require positive discipline practices and prohibit inappropriate ones. Programs should adhere to one baseline set of regulations, which include:
    a. Setting behavioral expectations through discipline policies that are shared with families;
    b. Prohibiting corporal punishment and inappropriate discipline, with specific areas that align with *Caring for Our Children Basics*;[24]
    c. Emphasizing redirection of negative behaviors and reinforcement of positive behaviors as discipline strategies; and
    d. Providing parameters on when to use time outs by age level.
2. Use one consistent definition for each of the following:
    a. "Corporal punishment" means any kind of punishment inflicted on a child's body.
    b. "Discipline" means an ongoing process of instruction, affirmation, and correction that helps children develop self-control and other pro-social traits while protecting and maintaining self-esteem, confidence, and self-efficacy.
    c. "Punishment" means the use of negative consequences to stop unwanted behavior.
3. Remove regulations related to interactions between staff and children not directly related to discipline.

Rationale

Currently, there are discipline and behavior regulations in Indiana Administrative Code for homes and centers, and in Indiana Code for CCDF voucher recipients. While many of the regulations meet best practice (e.g., prohibiting corporal punishment and inappropriate discipline, sharing discipline policies with parents), they use different language and terminology across the regulatory sets (e.g., homes define discipline differently than centers). The above recommendations would streamline the language and expectations across programs while ensuring Indiana is meeting best practice. Further, practices such as positive behavioral approaches prevent the suspension or expulsion of young children, which must be addressed in CCDF State Plans. Finally, regulations on interactions that are part of process quality, and not health and safety, can be removed as they will be covered in the revised PTQ™.

---

[23] World Health Organization. (2021, November 23). *Corporal punishment and health.* https://www.who.int/news-room/fact-sheets/detail/corporal-punishment-and-health

[24] Head Start Early Childhood Learning & Knowledge Center. (2022). *Prohibited caregiver/teacher behaviors.* U.S. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/prohibited-caregiverteacher-behaviors

Regulatory Area:

Behavior & Guidance – Activities and Programming

From a health and safety perspective, the regulatory area of activities and programming ensure that opportunities to support child development are age-appropriate and ensure access to outdoor time where children can practice fine and gross motor skills.[25] Regulations in this area also promote practices that reduce health risks such as inappropriate screen time use.

Recommendations

1. Use consistent language that requires all programs to provide access to age and developmentally appropriate activities; quiet and active play times; and outdoor play.
2. All programs should adhere to a screen time regulation, using Louisiana's child care licensing regulation as a basis. This regulation states:
    a. no electronic device activities for children under age two;
    b. less than two hours a day of screen time for children age two or older, with television, DVD or video viewing limited to one hour a day.[26]

Rationale

The recommendations would greatly shorten the number of regulations centers have to adhere to, which currently include several quality-related sections that are being addressed in Paths to QUALITY™. Quality-focused sections that could be removed include: 470 IAC 3-4.7-60, 470 IAC 3-4.7-61, 470 IAC 3-4.7-63, 470 IAC 3-4.7-146, 470 IAC 3-4.7-59, 470 IAC 3-4.7-132, 470 IAC 3-4.7-133.

The recommendations for the remaining items in this section align with best practices for supporting children's health and safety through activities and programming. Specific regulations on physical activities are included to ensure children have opportunities to develop their gross and fine motor skills. A rule on screen time is included to reduce the potential for health issues related to screen use.[27]

---

[25] Administration for Children and Families. (2015). *Caring for Our Children Basics*. See Active Opportunities for Physical Activity (Section 3.1.3.1). https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf

[26] See Louisiana Administrative Code Title 28. Bulletin 137, Section 1509 (9): (a) electronic device activities for children under age two are prohibited; and (b) time allowed for electronic device activities for children ages two and above shall not exceed two hours per day, with the exception that television, DVD, or video viewing shall be limited to no more than one hour per day.

[27] Mayo Clinic Staff. (2022, February 10). Screen time and children: *How to guide your child*. Mayo Clinic. Retrieved from https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/screen-time/art-20047952

Family Engagement

Family Engagement

Regulatory Area:

Family Engagement

Keeping a child safe is a collaborative effort between an early learning program and a child's parents and guardians. *Caring for Our Children Basics* states: "The quality of the relationship between parents/guardians and caregivers/teachers has an influence on the child. There should be a reciprocal responsibility of the family and caregivers/teachers to observe, participate, and be trained in the care that each child requires, and they should be encouraged to work together as partners in providing care."[28] As such, ensuring families understand the policies and procedures in place that will protect their child is a key aspect of an early childhood program.

Recommendations

1. All programs should allow unscheduled visits by parents and guardians any time a child is in care and parents should be notified of this right. Further, all programs should:
    a. Conduct regularly scheduled conversations with parents about a child's progress, development, and (as applicable) challenges, including any updates to the child's health record. These conferences or conversations should be offered at least every six months if a child is less than six years old.
    b. Engage in enrollment practices that include:
        - Providing, in writing, the program's:
            > Provisions for emergency medical care
            > Provisions for treatment of illness
            > Policy regarding visits, field trips, or excursions
        - Receiving a statement that documents the child's parent(s), legal guardian(s), and other authorized people to whom a child can be released; and
        - Collecting from families and filing all relevant legal documents, court orders, etc. Caregivers should comply with court orders and written consent from the parent/guardian with legal authority.

Rationale

Regardless of where a child is enrolled, families have a right to know how a program will keep their children safe from harm in the case of emergency, illness, or in spaces where a child may be exposed to new places or people. Programs must be aware of whom the child can be released to for the safety of the enrolled child.

It is a federal requirement that programs allow parents or guardians unlimited access to their children during their regular operating hours or any time a child is being cared for by a program.[29]

---

[28] National Resource Center for Health and Safety in Child Care and Early Education. (2022). Caring for Our Children Online: Database Section 2.3.1. https://nrckids.org/CFOC/Database/2.3.1

[29] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register, 81(190), 67484, Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

National standards of best practices outlined by Child Care Aware® of America (Level 2) states that programs should also provide written policies and regular updates on a child's development.[30] This is further supported by *Caring for Our Children Basics*, which discusses the importance of open communication between parents and programs and suggests the use of parent/guardian conferences scheduled on a periodic basis to review and discuss a child's adjustment and development.[31]

[30] Child Care Aware® of America. (2020). *Child Care Licensing Benchmark Project*. https://info.childcareaware.org/hubfs/ChildCare-BenchmarkLicensingProject-FINAL-11022020.pdf

[31] National Resource Center for Health and Safety in Child Care and Early Education. (2022). *Caring for Our Children Online: Database Section 2.3.2*. https://nrckids.org/CFOC/Database/2.3.2

Environment and Facilities

Bathrooms
Fire Safety and Prevention
Firearms
Outdoors and Playground
Pest Management
Electrical Devices and Sources
Telephone
Toxic and Hazardous Materials
Ventilation
General/Other

Regulatory Area:

Environment and Facilities – Bathrooms

Bathrooms can pose several safety hazards to children, including drowning, hazardous chemicals, falling, and electrical shock.[32] Sinks are necessary for hand-washing procedures that reduce risk of the spread of disease, yet should be accessible and secured so that they do not pose a risk of falling on children. The availability of clean water is important for children's health. Working plumbing and sewage also reduce health risks.

Recommendations

1. All programs should have:
    a. Child-appropriate toilets and sinks, and a process for ensuring children can access toilets or sinks that are not age-appropriate (e.g., a stable, slip-proof step platform for a sink not at a child's height);
    b. Ratios for the number of toilets to children in non-residential settings, organized by developmental period (e.g., infants/toddlers, preschool, school age); for residential settings, at least one (1) flush toilet and a sink must be accessible to children on each floor of the residence where services are provided;
    c. Sinks with hot and cold running water;
    d. Bathroom supplies that include availability of toilet paper, soap, and disposable towels (or electrical hand dryers) that are within reach of children;
    e. Secured equipment in bathrooms (e.g., sinks);
    f. Pipes, plumbing, and sewage systems that meet state and local regulations; and
    g. Water that is tested and determined safe and sanitary.

Rationale

While regulations to keep bathrooms, plumbing, and water supply safe and healthy are critically important, stakeholders report significant financial challenges in meeting them due to the high cost involved with renovations to an existing facility or finding a new facility. As these recommendations were developed, this factor was considered alongside best practices. The Bipartisan Policy Center's facilities framework for child care informed the final recommendations.[33]

The recommendation related to ratios of toilets to children differs by setting due to the different nature of residential-based and non-residential settings. Residential-based child care is in a home and typically serves a smaller number of children. Thus, the recommendation recognizes this fact and seeks to avoid undue burden on these programs. Additionally, regulations for infants and toddlers and school-age children are included to recognize special developmental considerations—for instance, school-age children's need for more privacy.

These recommendations streamline and, at times, reduce language and duplication in what is currently in Indiana Administrative Code to provide consistent language and expectations on safety and health related to bathrooms, water supply, and plumbing.

---

[32] eXtension Alliance for Better Child Care. (2019). *Bathroom safety in child care.* https://childcare.extension.org/bathroom-safety-in-child-care/

[33] Morris, S., Tracey, S., & Smith, L. K. (2021). *Best practices for family child care facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

Regulatory Area:

Environment and Facilities – Fire Safety and Prevention

Fire safety and prevention practices minimize the potential for fires to start, including keeping combustible materials away from potential spark sources. They also protect children from harm should there be a fire incident on site. These measures include having exits that children and staff can quickly reach and move through, and preparedness practices such as fire drills to act quickly in an emergency.

Recommendations

1. All programs should be in compliance with fire code at the time of licensure and have:
    a. Functioning smoke detectors and fire extinguishers throughout the building, with batteries for smoke detectors tested monthly;
    b. At least two exits that are convenient, accessible, and unobstructed. For non-residential settings, emergency exits are clearly identified;
    c. Environments, including furnace areas, that are clear of preventable fire hazards (e.g., not having combustible material near furnaces or water heaters); and
    d. Emergency lighting when normal lighting system fails, with testing of the system monthly (residential settings exempted).

Rationale

Currently, Indiana Code directs homes, centers, ministries, and the school-age grant program to be in compliance with fire safety rules, and programs receiving CCDF vouchers have a separate set of fire safety rules. Fire safety is addressed across all programs in Indiana Administrative Code, though at times across multiple sections or using duplicative language. The recommendations streamline fire safety regulations and focus on the key practices associated with fire safety as outlined in guidance from the Bipartisan Policy Center's facilities framework.

---

[34] Fire drills and inspections are in separate sections. This section focuses solely on building-related fire prevention and safety.

[35] Bipartisan Policy Center. (2021). *Moving towards quality: Child care center facility assessment checklist.* https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Checklist1.pdf; Morris, S., Tracey, S., & Smith, L. K. (2021, September). *Best practices for family child care facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

Regulatory Area:

Environment and Facilities – Firearms

Rules pertaining to firearms prevent children from accessing firearms to keep them and others safe from firearm-related injuries.

Recommendations

1. All programs should have a policy and procedure on firearms safety that is shared with parents.
    a. Non-residential sites should prohibit firearms, unless the firearm is required as a condition of employment.
    b. Residential sites must follow safety procedures if there is a firearm on site. This includes: ammunition and firearms be kept in a locked area inaccessible to children at all times; and the firearm is unloaded, equipped with protective devices, and stored separately from ammunition.

Rationale

Child Care Aware® of America's Licensing Benchmark Level 2 for Health and Safety recommends programs develop policies and procedures on firearms safety. The American Academy of Pediatrics, the American Public Health Association, and *Caring for Our Children Basics* offer best practice as follows:[36]

- No firearms on premises;
- If there are firearms, they are stored safely. This includes making sure each firearm is: unloaded, equipped with protective devices, kept under lock and key, and stored separately from ammunition; and
- Parents know the program's policy on firearms.

The recommendations differ between non-residential and residential settings. In residential settings, the homeowner or other individuals may own firearms in the areas where they reside. Thus, rules for residential settings are designed to ensure children do not have access to firearms. The recommendation builds on what is currently in code to adhere to best practice. Meanwhile, non-residential settings should restrict firearm carriage on site to those who carry one as a condition of their employment. This is currently implied through 470 IAC 3-4.7-19, which lists prohibition of firearms unless a condition of employment as a posted items requirement. Pulling it into its own section would make this more explicit.

[36] Benjamin-Neelon, S. E., & Grossman, E. R. (2020). State regulations governing firearms in early care and education settings in the US. *JAMA network open, 3(4)*, e203321. https://doi.org/10.1001/jamanetworkopen.2020.3321. Guidance based off of review of firearm standards put forth by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education.

Regulatory Area:

Environment and Facilities – Outdoors and Playground

Outside play opportunities are important for young children's physical and mental development, yet also pose many potential risks for injury such as falling off playground equipment or drowning in nearby bodies of water.[37] Engaging in preventative measures decreases these risks. Along with the physical safety of equipment and outside areas, programs should engage in practices that support active supervision of children.

Recommendations

1. All programs adhere to a consistent set of outdoor play area regulations, including:
    a. Outdoor play areas are enclosed by a fence or natural boundary;
    b. A minimum of 75 square feet of space for each child;
    c. The area is free from hazardous elements;
    d. Appropriate safety surfaces are used to prevent injury from falls;
    e. Play structures and equipment that are in good condition and inspected for hazards daily;
    f. Outdoor play areas and equipment are well drained and free from standing water; and
    g. When outdoor play areas are not accessible on site, precautions are in place to protect children if they have to cross a traffic area (e.g., street, alley, parking lot) to a playground or other outside play area. All programs should follow these procedures:
        - Children only cross a traffic area if assisted;
        - Children wait at the edge of the traffic area;
        - The caregiver moves to the center of the traffic area and assures that no autos are present or that all traffic is stopped;
        - The caregiver remains in the center of the traffic area until the last child has safely crossed the area; and
        - When crossing public streets or other areas regularly traveled, caregivers shall display a flag, "Stop" sign, or other effective sign designed to halt traffic while children cross the area.

Rationale

Currently, homes, centers, and voucher recipients have some level of regulation around outdoors and playgrounds (e.g., outdoor space must be fenced or have natural barriers). The above recommendations pull from and condense language currently in several sections for centers (e.g., 470 IAC 3-4.7-68; 470 IAC 3-4.7-69; 470 IAC 3-4.7-66; 470 IAC 3-4.7-670) to focus on key best practices derived from the Bipartisan Policy Center's facilities guidance for centers and homes.[38] The state should consider using guidance from the US Consumer Product Safety Commission's (CPSC) Public Playground Safety Handbook and ASTM International Standards F1292-13 and F2223-10[39] in determining equipment safety. Regulations that keep outdoor play areas safe, while minimizing risk of injury, death, or ill health, are applicable to any program serving children.

---

[37] The National Center on Early Childhood Quality Assurance. (2020). *Building and physical premises safety brief #5: Building and physical premises safety.* U.S. Administration for Children and Families. https://childcareta.acf.hhs.gov/sites/default/files/new-occ/resource/files/building_safety_brief_5_2020.pdf

[38] Bipartisan Policy Center. (2021, April). *Moving towards quality: Child care center facility assessment checklist.* https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Checklist1.pdf; Morris, S., Tracey, S., & Smith, L. K. (2021, September). *Best practices for family child care facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

[39] Administration for Children and Families. (2015). *Caring for Our Children Basics*. https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf

Regulatory Area:

Environment and Facilities – Pest Management

Pest management practices reduce children's exposure to disease, asthma attacks, bites, and stings. Because young children spend a significant amount of time on the floor and often place objects and their hands inside their mouth, reducing exposure to pests and avoiding use of pesticides is important as a part of licensing.[40]

Recommendations

1. All programs should have a pest management system in place that:
    a. Reduces pathways for pests to enter the premises, such as mesh screens on windows and doors and sealing cracks around pipes, plumbing, and ducts;
    b. Requires that garbage cans are covered tightly, frequently emptied to an outside source, and cleaned when soiled; and
    c. Ensures children are not present during any extermination procedures.

Rationale

Currently, all settings (except rules governing CCDF voucher programs) have some level of regulation that includes pest management practices, though they place them in differently titled sections (e.g., an item in "Sanitation" or, in the case of centers, multiple separated sections such as garbage and refuse and pest prevention). The above recommendations consolidate this information in one place and are aligned with best practices informed by *Caring for Our Children Basics* (5.2.8.1) and the Bipartisan Policy Center's facilities framework.[41]

---

[40] United States Environmental Protection Agency. (2023). *Resources about pesticides and integrated pest management for child care providers.* https://www.epa.gov/childcare/resources-about-pesticides-and-integrated-pest-management-child-care-providers.

[41] Bipartisan Policy Center. (2021). *Moving towards quality: Child care center facility assessment checklist.* https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Checklist1.pdf; Morris, S., Tracey, S., & Smith, L. K. (2021, September). *Best practices for family child care facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

Regulatory Area:

Environment and Facilities – Electric Devices

Electric devices and sources of electricity pose potential for electrocution of children and staff. When devices such as fans have blades, there is risk for injury if children can place their fingers or other appendages near moving blades. Devices that pose fire hazards are also included as inappropriate devices.

Recommendations

1. All programs should:
    a. Have tamper-resistant electrical outlets, safety covers, or safety plugs that prevent children from sticking fingers or objects into electrical outlets;
    b. Use extension cords only if necessary. Any extension cords used are approved and grounded. Any surge protection strips in use must be nationally rated. The protection strips are plugged directly into an approved outlet;
    c. If fans or heaters are used, use models that are protected by safety devices that will not allow a child's fingers to come in contact with the blade or heating element; and
    d. Ensure that electrical devices that are plugged in are not accessible to children while in contact with water sources (sinks, tubs, shower areas, water tables, swimming pools, or other bodies of water).

Rationale

Caring for Our Children Basics was used to identify best practices in this area.[42] Homes and centers currently have regulations on covering exposed electrical outlets and preventing children from reaching into fans, though centers have slightly different specifications. Following the recommendation would create consistency and ensure all programs adhere to best practices to keep children safe from devices using electricity.

[42] Administration for Children and Families. (2015). *Caring for Our Children Basics.* See Sections 5.2.4.2, Safety Covers and Shock Protection Devices for Electrical Outlets and Section 5.2.4.4, Location of Electrical Devices near Water. https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf.

Regulatory Area:

Environment and Facilities – Telephone

The ability to communicate by phone is important for making calls in emergency situations and for general use to communicate with parents, staff, and others.[43]

Recommendations

1. All programs have a:
    a. Working telephone on site; and
    b. Wireless communication available when transporting children and on field trips.

Rationale

In its framework for facilities, the Bipartisan Policy Center recommends centers and homes have working landlines, or (for homes) access to alternative power sources for phone communication.[44] *Caring for Our Children Basics* recommends availability and use of a telephone or wireless communication device, and that communication devices are available when transporting children and on field trips.[45]

Currently, Indiana Administrative Code requires a telephone on site for homes, centers, and voucher recipients. This recommendation would streamline and, in some cases, simplify the language. A recommendation that a wireless communication device is available when staff are with children outside the site (i.e., transporting and on field trips) is added to adhere to best practice, ensuring staff have access to make emergency calls or calls to families when offsite.

---

[43] Administration for Children and Families. (2015). *Caring for Our Children Basics.* https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf

[44] Bipartisan Policy Center. (2021). *Moving towards quality: child care center facility assessment checklist.* https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Checklist1.pdf;

Morris, S., Tracey, S., & Smith, L. K. (2021). *Best practices for family child care facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

[45] Administration for Children and Families. (2015, June 25). *Caring for Our Children Basics.* See Section 5.2.4.2, Safety Covers and Shock Protection Devices for Electrical Outlets. https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf

Regulatory Area:

Environment and Facilities – Toxic and Hazardous Materials

Children's exposure to toxic and hazardous materials poses a health and safety risk above and beyond that of adults because of children's developing bodies. Additionally, young children engage in activities such as crawling on floors and placing objects and hands in their mouth that create a multitude of opportunities for substances to enter their bodies.[46] Toxic cleaning substances, carbon monoxide, lead, and other toxins can cause death or long-term injury to young children. As a prevention strategy, children should also be kept away from hazardous tools and thermal hazards that can easily inflict damage to their bodies, and from areas that pose a hazard for entrapment or burial.

Recommendations

1. All programs should have regulations that keep toxic or hazardous materials from children. This includes[47]:
    a. Making the following inaccessible to children: cleaning equipment, medication, sharp tools, flammable materials, or other items that state "keep out of the reach of children";
    b. Placing items that are "fatal if swallowed" in locked storage and away from children;
    c. Ensuring lead levels in peeling paint are not in excess of Indiana State Department of Health standards;
    d. Keeping thermal hazards (e.g., radiators, steam pipes) and combustible materials away and out of reach of children; and
    e. Making environmental risks for entrapment or burial (e.g., pits, abandoned wells, abandoned appliances) inaccessible to children.

Rationale

Federal regulations require programs to address the handling and storage of hazardous materials and the appropriate disposal of biocontaminants as part of health and safety requirements.[48] Toxic and hazardous materials pose clear threats to child health and safety, and precautions must be taken to minimize access to such materials. The recommendations above align with best practices such as assessing and addressing any potential toxic or hazardous materials and reducing children's potential for exposure.[49]

---

[46] National Center on Early Childhood Quality Assurance. (2016). *Handling, storing, and disposing of hazardous materials and biological contaminants.* https://childcareta.acf.hhs.gov/sites/default/files/brief_7_hazardousmaterials_final.pdf

[47] Posting the poison control number is a best practice that is included in the "First Aid and Emergency Contacts" section.

[48] National Center on Early Childhood Quality Assurance. (2016). *Handling, storing, and disposing of hazardous materials and biological contaminants.* https://childcareta.acf.hhs.gov/sites/default/files/brief_7_hazardousmaterials_final.pdf

[49] Administration for Children and Families. (2015). *Caring for Our Children Basics.* See Sections 5.1.1.5, Environmental Audit of Site Location and 5.2.9.1, Use and Storage of Toxic Substances. https://www.acf.hhs.gov/sites/default/files/documents/ecd/caring_for_our_children_basics.pdf; Bipartisan Policy Center. (2021, April). *Moving towards quality: Child care center facility assessment checklist.* https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Checklist1.pdf; Morris, S., Tracey, S., & Smith, L. K. (2021, September). *Best Practices for Family Child Care Facilities: Supporting our youngest learners.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/10/ECI-Facilities-Best-Practices_Final-compressed.pdf

Regulatory Area:

Environment and Facilities – Ventilation

Proper ventilation supports healthy breathing, particularly for children with respiratory illnesses or chronic health conditions, and reduces the risk of the spread of infectious diseases, protecting children and staff.[50] Associated with ventilation is the condition of the air in the space, such as air temperatures that do not pose a threat to children's health (e.g., avoiding extreme heat or cold). Ventilation includes practices such as opening windows, using fans, and having a heating, ventilation, and air conditioning (HVAC) system.

Recommendations

1. All programs should have:
    a. An appropriate heating, ventilation, and air conditioning (HVAC) system in place, in good working order, in compliance with the Fire Prevention and Building Safety Commission, and with a preventive maintenance plan;
    b. Restrooms that are ventilated to the outside;
    c. Appropriate room temperatures maintained in all rooms.
        i. During winter months temperatures are no lower than 68 degrees Fahrenheit;
        ii. During summer months, temperatures do not exceed 82 degrees Fahrenheit;
    d. Prohibitions against heat sources that are dangerous (e.g., open grate gas heaters, open fireplaces, space heaters, portable unventilated oil-burning heaters, and portable electric heaters); and
    e. Measures in place so that children cannot access heating units.

Rationale

While nearly all settings have rules on ventilation, they have items presented in different sections, at times with redundancy, and use different titles for these rules (e.g., sanitation; buildings, grounds, equipment, furnishings, materials and supplies; heat, light, ventilation, and air conditioning, etc.). Thus, having one dedicated section to ventilation and HVAC would create consistency and reduce any redundancy. The recommendations were informed by best practice guidance produced by the Bipartisan Policy Center.[51] For air temperature specifications, the Bipartisan Policy Center recommends following guidelines from the American Society of Heating, Refrigerating, and Air Conditioning—the minimum temperatures during winter and maximum during summer are used in the recommendation.

---

[50] Early Childhood Learning & Knowledge Center. (n.d.). *Ventilation and healthy air.* U.S. Department of Health and Human Services. https://eclkc.ohs.acf.hhs.gov/browse/tag/ventilation-healthy-air

[51] Tracey, S., Smith, L.K., & Rosen, S. (2021). *Moving towards quality: Model improvement standards for existing center-based child care facilities.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Report.pdf

Regulatory Area:

Environment and Facilities – General/Other

This section provides general directives not covered by other environment/facilities sections to ensure the environment is safe for children.

Recommendations

1. All programs should:
    a. Provide child care services in a structurally sound building and in conditions that would not harm children's health, safety, or welfare;
    b. Operate a site that is clean, safe, sanitary, and in a good state of repair;
    c. Have site interiors that are in clean and sanitary condition, with nontoxic durable construction, and adhere to fire safety regulations;
    d. Clean the site daily; staff only do major cleaning when children are not present (unless to address immediate safety concerns such as spills);
    e. Keep children away from areas that are being remodeled, repaired, or painted;
    f. Have interior room and closet doors that allow children to open them to prevent children from locking themselves inside;
    g. Have lighting that is sufficient for staff to supervise children (i.e., children can be seen);
    h. Have flooring that is smooth and made of washable, nonslippery material and cleaned daily and maintained. Firmly secure and keep clean any carpeting. Use small rugs only in areas where children are not served, with an exception for nonslip rugs in bathrooms;
    i. Have furnishings that are durable, safe, and scaled to the size of the children, with tables not stacked when children are present; and
    j. Adhere to special considerations for infant/toddler rooms to meet the needs of very young children, including: availability of changing tables that can be sanitized; rooms not being used a throughway; and stairways that are not blocked and inaccessible.

Rationale

Programs receiving CCDF vouchers are required to ensure that buildings and the environment are safe and healthy for children. *Caring for Our Children Basics* and facilities guidance from the Bipartisan Policy Center were used to inform these recommendations. The recommendations seek to ensure program facilities are structurally safe, free of environmental hazards, and reduce risk of injury. For example:

- Prohibiting infant/toddler rooms from being used as a throughway limits the amount of foot traffic in the area. This is important because children of this age crawl and frequently put their hands in their mouth. Limited foot traffic decreases the potential for germs to enter children's bodies.

[52] Tracey, S., Smith, L.K., & Rosen, S. (2021). *Moving towards quality: Model improvement standards for existing center-based child care facilities.* Bipartisan Policy Center. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/04/Moving-Towards-Quality-Report.pdf

- Conducting major cleaning only when children are not present prevents children's exposure to cleaning materials and ensures caregivers are able to fully supervise children by not engaging in other tasks. The exception is for spills that cause immediate dangers for slipping or other safety hazards.
- Restricting the use of small rugs is important because they are a tripping and slipping hazard. An exception is made for small nonslip rugs in bathrooms to provide traction if the area is slippery from water. Carpeting regulations are in place to reduce tripping hazards.

The recommendations reduce and streamline what is currently in IAC for different settings, and significantly reduce regulations for centers.

Food Preparation and Service

Kitchen Practices

Dishwashing

Food Delivery

Feeding

Nutrition

Regulatory Area:

Food Preparation and Service – Kitchen Practices

Regulations related to kitchen practices focus on ensuring that kitchen set-up, use, and sanitation practices prevent foodborne illnesses and minimize any physical harm to children and staff, such as burns, cuts, or scalding from hot water. Rules and regulations governing kitchen practices should focus on the design of the space, proper storage and temperature control, and safe handling practices.

Recommendations

1. All programs should adhere to best practices across six areas:
    a. Location of Food Preparation Areas: Food preparation areas (kitchen space) should be separate from other areas of the program and not used as passage or throughways. The only exception should be allowed for residential settings if it impacts caregivers' ability to supervise children safely.
    b. Equipment: The kitchen is equipped with: (1) a stove and oven or microwave; (2) a refrigerator; and (3) a sink with hot and cold running water; in operating condition sufficient to accommodate the food requirements of the number of children in care. All equipment should be maintained appropriately. Regarding the definition of equipment, Indiana can work toward an acceptable definition that is inclusive of refrigerators, ovens, ranges, freezers, and other necessary equipment to prepare and store food or sanitize before and after food preparation.
    c. Sinks: There should be at least two sinks: one exclusively for hand washing and the other for dishwashing.
    d. Sanitation Practices: All food prep, serving items, and utensils are sanitized daily.
    e. Staff Hygiene: Staff engage in hygienic practices that include frequency of hand washing and the use of hair nets and washable garments.
    f. Prohibitions on Use: The kitchen and food preparation area may not be used for children's activities or naps, a dining or recreational area for adults, or as an office.

Rationale

Current Indiana Administrative Code (IAC) provides guidance on kitchen practices for homes, ministries, and centers, but the rules are slightly different depending on setting. Table 1 summarizes the overlap and difference between the current regulations governing homes, ministries, and centers. Further, there is overlap between the language of the IAC governing ministries and centers. Creating one set of regulations that apply across early childhood programs will clarify what is absolutely necessary for child safety, support consistency, and ease enforcement practices, effectively reducing confusion for early childhood programs.

Table 1: Summary of Kitchen Prep Provisions in IAC, depending on Early Childhood Setting

Summary of Provision in IAC	Homes	Ministries	Centers
Sanitize all food prep, serving items, and utensils daily	X	X	X
Definitions		X	
Kitchen in a separate area		X	X
Refrigerators and freezers available and working with thermometers		X	X
Maintained ranges located on site		X	
Stored food and storage containers at least 6 inches above the floor		X	
Separate sink exclusively for handwashing		X	X
Smooth countertops			X
Prohibitions on the use of the kitchen for other purposes		X	X
Kitchen staff rules around hand washing and expectations for uniform (i.e. hair net and clean aprons)		X	X

Regarding the content of the suggested regulations, the design and set-up of a kitchen space, when constructed properly, is conducive to ensuring the health and safety of children and staff members. Practicing safe food handling practices is also imperative for preventing physical harm (e.g., burns, infectious disease, or food poisoning). *Caring for Our Children Basics* states that children should be supervised in areas where hot food is being prepared by adults who are trained in sanitation and safety.[53] These standards, along with the Bipartisan Policy Center facilities checklist, provide national standards of best practice guidance about kitchen set-up and sanitation procedures that were used to inform the regulation categories listed above.[54]

[53] U.S. Department of Health & Human Services, Administration for Children and Families, Office of Head Start. (2022, September 29). *Caring for Our Children Basics*: Food Preparation Area Access. Early Childhood Learning and Knowledge Center. Retrieved from https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/food-preparation-area-access

[54] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), Chapter 4: Nutrition and Food Service, 4.8 Kitchen and Equipment*. https://nrckids.org/CFOC/Database/4.8.0

Regulatory Area:

Food Preparation and Service – Dishwashing

A process for thoroughly washing and sanitizing dirty dishes is a preventative measure against cross-contamination and foodborne illness or allergies for young children.

Recommendations

1. Programs responsible for washing dishes should adhere to the following rules:
    a. Any program that washes dishes by hand should have a dishwashing station with a three-compartment setup with temperature ranges provided for compartment 1 and compartment 3; and
    b. Any program that uses a dishwasher should run it on a sanitizing cycle or on a cycle that uses heat for full sanitization.
2. The rules should clarify the proper water temperature ranges for the three-compartment sink. For example, the regulation should say that sink compartment #1 should have water that is temped between 110-170 degrees.

Rationale

Ensuring proper sanitation and hygiene practices for dishes and utensils is an important health and safety practice to guard against infectious disease and minimize risk of illness for both children and staff. *Caring for Our Children Basics* has a set of standards for properly washing dishes.[55] The standards state that any dishwashing station should have a three-compartment setup, with a recommended use and water temperature for the three compartments and air drying after cleaning.

The water temperatures listed in the current regulations (470 IAC 3-4.5-5 Food service sanitation) are temperature minimums. However, conversations with licensing consultants shared that regulations about specific water temperature only set minimums, but they had concerns about the water temperature being too hot sometimes and therefore a risk of scalding or burns.

[55] National Resource Center for Health and Safety in Child Care and Early Education. (2023, June 16). *Caring for Our Children (CFOC), Chapter 4: Nutrition and Food Service,* 4.9 Food Safety. https://nrckids.org/CFOC/Database/4.9.0.11

Regulatory Area:

Food Preparation and Service – Food Delivery

When partnering with an outside food vendor to provide food for young children, basic health and safety precautions prevent the spread of foodborne illnesses.

Recommendations

1. Indiana may consider cross-referencing food delivery rules with the Indiana Department of Health, but in general, one rule should apply for all programs and focus on two main points:
    a. Staff should wash and sanitize all food preparation areas, serving areas, and utensils on a daily basis; and
    b. Each program using vendor service shall have a written contract that assures that the vendor's food service business, food handlers, and all premises are inspected and approved by local health authorities.

Rationale

Current regulations appear to be highly burdensome for centers and 470 IAC 3-4.7-83 subsection (b) is a provision that is not within the control of the early childhood program and therefore not relevant to their licensing provision. According to national standards of best practice (Child Care Aware® of America's Licensing Benchmark Project and *Caring for Our Children Basics*), guidance on food safety standards addresses the need to ensure that food provided by central kitchens or vendors is obtained from approved and inspected sources by the local health authority.[56]

[56] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). Caring for Our Children (CFOC), Chapter 4: Nutrition and Food Service, 4.4 Staffing. https://nrckids.org/CFOC/Database/4.4.0.2

Regulatory Area:

Food Preparation and Service – Feeding

Regulations on feeding are different from nutrition because they cover topics regarding food preparation and storage (including breastmilk and formula) as well as addressing choking hazards and the cadence and structure of meal times. Because child care programs are responsible for preparing food and drinks, proper handling is important to prevent foodborne illness, manage safety at meal times, and ensure young children have sufficient time to eat.

Recommendations

1. All programs should adhere to the following components:
    a. General Meal Guidelines: A discussion on how to conduct meals safely with adequate supervision and age-appropriate equipment.
    b. Storage and Handling of Human Breastmilk: Human milk storage and handling guidelines should be updated to be reflective of the most recent Academy of Breastfeeding Medicine Protocol #8 from 2017.[57]
    c. Toddler Feeding: Sanitation, hygiene, and age-appropriate best practice for preparing food and feeding toddlers.
    d. Infant Food Preparation and Storage: This section should focus on safe practices for preparing and storing infant food.
    e. Infant Feeding Practices: Rules focus on the safety of handling disbursement of infant food.
    f. Night Care Food Service: Clarifying which meals are expected if a child is enrolled in night care.
    g. Picnics: This section focuses on safety during outdoor meal service, particularly with grills.
    h. Special Meals/Allergies: Provide rules about managing safety and care for children with allergies or religious preferences.
2. Add clarification that programs can either choose to provide food or may choose to not provide food and instead require parents to provide a child's food for the day. This section of regulatory code should clarify what programs are still responsible for, such as but not limited to:
    a. Adhering to safe food handling practices;
    b. Providing water throughout the day to children;
    c. Having some snacks on-hand in case food from home is insufficient;
    d. Safe food storage options (refrigerator and bottle warmers, etc.); and
    e. General meal time requirements, as applicable.

[57] Eglash, A., Simon, L., & The Academy of Breastfeeding Medicine. (2017). ABM clinical protocol #8: Human milk storage information for home use for full-term infants, Revised 2017. *Breastfeeding Medicine*, 12(7), 390 – 395. https://www.bfmed.org/assets/DOCUMENTS/PROTOCOLS/8-human-milk-storage-protocol-english.pdf

Rationale

The Administration for Children and Families (ACF) "strongly encourages Lead Agencies" to include basic health and safety guidelines such as age-appropriate feeding.[58]

The national standards for best practices focus on following procedures developed by the Academy of Breastfeeding Medicine Protocol for storing and serving human milk, cutting solid food to the correct size to avoid choking hazards, and providing ongoing supervision during mealtimes to prevent choking. Further, programs should develop protocols for serving children with food allergies and ensure on-site staff are trained in allergy prevention, recognition, and treatment.

While the Indiana Licensing Workgroup does not address these specific regulations, conversations with providers and licensing specialists shed light on some of the regulatory challenges in this set of rules. For example, providers felt that the stringent regulations around meal times do not allow for the reality of managing a classroom of young children, citing that they could be out of compliance if an educator gets up from the table to grab a paper towel while children are eating.

By updating the regulations to align with best practices and focus the scope on child health and safety, they will be less burdensome.

Finally, the regulatory code does not specifically clarify that programs do not have to manage the food service and that it may be acceptable for programs to ask parents to provide food from home for all snacks and meals. This lack of clarity should be resolved.

---

[58] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register, 81(190), 67484, Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67484). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

Regulatory Area:

Food Preparation and Service – Nutrition

Children enrolled in child care programs may consume two snacks and one main meal while in attendance. High-quality nutrition and appropriate caloric intake are crucial for positive and lasting impacts on a young child's cognitive development.[59]

Recommendations

1. All programs should adhere to the following:[60]
    a. The program must provide parents with written guidelines about food brought from home;
    b. Food provided for a child's main meals and snacks shall not be shared with other children;
    c. Potentially perishable food should be refrigerated; and
    d. Programs should keep some food on-site to supplement if a child's food from home is not sufficient to meet nutritional requirements.
2. All programs should adhere to federal Child and Adult Care Food Program (CACFP) requirements, with a core set of rules that apply to all programs and focus on the following components:
    a. Administrative items: providing written menu plan and information on vendor service for licensure;
    b. Adherence to a broad set of nutrition standards that comply with 7 CFR 226.20. For example, the revised Indiana Administrative Code should clarify the following:
        - For children starting at age (1) year old, their meal components should include the following and meet the dietary guidelines outlined by 7 CFR 226.20
            > BREAKFAST that offers age-appropriate servings of fluid milk, vegetables, and grains;
            > LUNCH and DINNER that offers age-appropriate servings of fluid milk, protein, vegetable, fruit, and grain; and
            > 2 SNACKS that must include at least two meal components outlined by 7 CFR 226.20.
        - Infant feeding throughout the day should adhere to the age-appropriate infant feeding components required by 7 CFR 226.20.
    c. Always providing clean, potable drinking water to children during all hours;
    d. Timing of meal service and how much time can pass before offering an infant or child more food;
    e. Prohibition on foods that are choking hazards; and
    f. Rules about dietary restrictions and special diets.

---

[59] Roberts, M., Tolar-Peterson, T., Reynolds, A., Wall, C., Reeder, N., & Rico Mendez, G. (2022). The effects of nutritional interventions on the cognitive development of preschool-age children: A systematic review. *Nutrients*, 14(3), 532. https://doi.org/10.3390/nu14030532

[60] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), Chapter 4: Nutrition and Food Service, 4.6 Food Brought From Home.* https://nrckids.org/CFOC/Database/4.6.0.1

Rationale

Some programs require parents to bring food in rather than providing on-site service. Food brought from home should be handled to minimize risk of food-borne illness or potential allergens.

Federal regulations recognize the importance of high-quality nutrition and age-appropriate feeding by stating: "Educating caregivers on appropriate nutrition, including age-appropriate feeding, and physical activity for young children is essential to prevent long-term negative health implications and assist children in reaching developmental milestones."[61] Child care programs are a significant source of food and nutrition for young children and ensuring that young children receive nutritious food and remain hydrated throughout the day are core components of their health and safety.

Federal requirements indicate that Lead Agencies should develop high-quality standards related to the topic of nutrition for young children.[62] In current IAC, centers and school-age settings are required to comply with the National Research Council Recommended Daily Dietary Allowances.

However, in conversation with Indiana early learning providers, they revealed their preference for Indiana's nutrition standards to comply with the Child and Adult Care Food Program (CACFP) standards (see summary in Figure 1 and Figure 2 below). This way, any program would be automatically eligible to receive reimbursement under CACFP rather than navigating two different sets of standards (IAC and CACFP).

Changing IAC to comply with CACFP (requirements are discussed in section below) would potentially reduce confusion and regulatory burden for providers. Further, there are some key components of national standards of best practices that are core to a child's well-being when in the care of any program. These include access to water and addressing choking hazards.

[61] U.S. Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Final Rule: Child Care and Development Fund (CCDF) Program* (p. 67484). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

[62] Ibid., (p. 67525).

Figure 1: CACFP Child Meal Patterns (table from the National CACFP Association)

The following tables provide guidance on meal patterns for breakfast, lunch, supper, and snacks by age range of children served and for adults. The tables are from the National CACFP Sponsors Association web-site (see the section for Meal Pattern Guidance).

BREAKFAST MEAL PATTERNS Serve Milk, Grains*, Vegetables or Fruit

COMPONENT	AGES 1-2	AGES 3-5	AGES 6-18	ADULTS
Milk	1/2 cup	3/4 cup	1 cup	1 cup
Vegetables, Fruit or Both	1/4 cup	1/2 cup	1/2 cup	1/2 cup
Grains	1/2 oz eq	1/2 oz eq	1 oz eq	2 oz eq

** Meat and meat alternates may be served in place of the entire grains component at breakfast a maximum of three times per week.* *oz eq = ounce equivalents*

LUNCH & SUPPER MEAL PATTERNS Serve all 5 components

COMPONENT	AGES 1-2	AGES 3-5	AGES 6-18	ADULTS
Milk	1/2 cup	3/4 cup	1 cup	1 cup*
Meat & Meat Alternates	1 oz	1 1/2 oz	2 oz	2 oz
Vegetables	1/8 cup	1/4 cup	1/2 cup	1/2 cup
Fruit	1/8 cup	1/4 cup	1/4 cup	1/2 cup
Grains	1/2 oz eq	1/2 oz eq	1 oz eq	2 oz eq

**A serving of milk is not required at supper meals for adults* *oz eq = ounce equivalents*

SNACK MEAL PATTERNS Serve 2 of the 5 components

COMPONENT	AGES 1-2	AGES 3-5	AGES 6-18	ADULTS
Milk	1/2 cup	1/2 cup	1 cup	1 cup
Meat & Meat Alternates	1/2 oz	1/2 oz	1 oz	1 oz
Vegetables	1/2 cup	1/2 cup	3/4 cup	1/2 cup
Fruit	1/2 cup	1/2 cup	3/4 cup	1/2 cup
Grains	1/2 oz eq	1/2 oz eq	1 oz eq	1 oz eq

oz eq = ounce equivalents

Figure 2: Summary of CACFP Infant Meal Patterns as Depicted by the National CACFP Association

The following tables provide guidance on meal patterns for breakfast, lunch, supper, and snacks for infants. The tables are from the National CACFP Sponsors Association website (see the section for Meal Pattern Guidance).

BREAKFAST	
Birth through 5 months	4-6 fluid ounces breastmilk[1] or formula[2]
6 through 11 months	6-8 ounces fluid breastmilk[1] or formula[2]; and 0-4 tablespoons infant cereal[2], meat, fish, poultry, whole egg, cooked dry beans, or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces (volume) of cottage cheese; or 0-4 ounces or 1/2 cup of yogurt[3]; or a combination of the above[4]; and 0-2 tablespoons vegetable or fruit or a combination of both[4,5]

LUNCH AND SUPPER	
Birth through 5 months	4-6 fluid ounces breastmilk[1] or formula[2]
6 through 11 months	6-8 ounces fluid breastmilk[1] or formula[2]; and 0-4 tablespoons infant cereal[2], meat, fish, poultry, whole egg, cooked dry beans, or cooked dry peas; or 0-2 ounces of cheese; or 0-4 ounces (volume) of cottage cheese; or 0-4 ounces or 1/2 cup of yogurt[3]; or a combination of the above[4]; and 0-2 tablespoons vegetable or fruit or a combination of both[4,5]

SNACK	
Birth through 5 months	4-6 fluid ounces breastmilk[1] or formula[2]
6 through 11 months	2-4 ounces fluid breastmilk[1] or formula[2]; and 0-1/2 slice bread[6]; or 0-2 cracker[6]; or 0-4 tablespoons infant cereal[2,6] or ready-to-eat breakfast cereal[4,6,7]; and 0-2 tablespoons vegetable or fruit, or a combination of both[4,5]

[1] Breastmilk or formula, or portions of both, must be served; however, it is recommended that breastmilk be served in place of formula from birth through 11 months. For some breastfed infants who regularly consume less than the minimum amount of breastmilk per feeding, a serving of less than the minimum amount of breastmilk may be offered, with additional breastmilk offered at a later time if the infant will consume more.
[2] Infant formula and dry infant cereal must be iron-fortified.
[3] Yogurt must contain no more than 23 grams of total sugars per 6 ounces.
[4] A serving of this component is required when the infant is developmentally ready to accept it.
[5] Fruit and vegetable juices must not be served.
[6] All grains served must be made with enriched or whole grain meal or flour. Ready-to-eat breakfast cereals and infant cereals that are fortified are also creditable.
[7] Ready-to-eat breakfast cereals must contain no more than 6 grams of sugar per dry ounce (no more than 21.2 grams sucrose and other sugars per 100 grams of dry cereal).

Health

Diapering
Health Policies
Pets and Animals
Prevention and Control of Infectious Diseases
Safe Sleep Practices and Rest

Regulatory Area:

Health – Diapering and Toilet Training

Proper procedures around diapering and toilet training protect the health and safety of both children and staff, and ensure care is developmentally appropriate.[63] These procedures prevent the spread of germs and keep children safe while on elevated surfaces such as changing tables.[64]

Recommendations

1. Focus on key health and safety components of diapering, following *Caring for Our Children Basics*. Diapering requirements for programs should include:
    a. Children are changed on a changing table or surface that is easily cleaned and sanitized after a diaper change;
    b. Staff changing diapers wash their hands before diapering (in addition to current regulations on washing hands after a diaper change);
    c. Staff keep a hand on the child at all times while diapering;
    d. Staff clean and sanitize the changing surface after the diaper change;
    e. Children's hands are washed after the diaper change; and
    f. Staff document the diaper change, diaper contents, and/or any problems.
2. Programs must empty toilet training chairs after each use and sanitize them at least daily.[65]

Rationale

Appropriate diapering and toilet training procedures should be followed regardless of child care program. Currently, diapering is addressed in Indiana Administrative Code for homes, ministries, and centers, but the level of specificity of the regulations varies by setting. Furthermore, only homes and centers have language addressing toilet training practices. The recommendations would promote consistent diapering and toilet training practices across programs and would streamline requirements for centers (e.g., no longer requiring parents to bring diaper bags to site).

---

[63] Early Childhood Learning and Knowledge Center. (2022). *Caring for Our Children Basics: Diaper Changing Procedure*. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/diaper-changing-procedure

[64] Rules prohibiting toilet learning/training methods that punish, demean, or humiliate a child are in the "Behavior" section of this document.

[65] Toilet training practices that humiliate or shame children should also be prohibited. This is covered in the "Discipline" section of this document.

Regulatory Area:

Health – Policies and Practices

This section addresses general health policies; child health records; immunization policies; administration and storage of medicine, first aid, and health emergency supplies; and prohibitions on smoking, alcohol, and drugs. Together, these policies and practices aim to prevent the spread of disease, reduce environmental toxins, equip staff to quickly respond to health emergencies, and ensure medications are safely administered.

Recommendations

1. All programs should:
    a. Create a program-wide policy that details the required health practices and procedures;
    b. Collect and maintain child health records that document initial and updated health care assessments completed and signed by the child's primary care provider, immunizations received, a parent-provided health history, and consent for emergency medical care. When caring for infants and toddlers, programs should also maintain daily records documenting care routines and health concerns;
    c. Require documentation of children's immunizations upon enrollment and updated annually (records should include child's date of birth and dates of immunizations received). Processes should be in place for when a child is unimmunized, including documentation of explanation (e.g., physician-approved medical reason, religious exemptions). Decisions on age-appropriate immunizations should come from the Indiana Department of Health;
    d. Have rules on administration and storage of medication that include documented permission from parents to administer medication to a child; labeling of the medication with the child's name; and storage of medication as indicated by manufacturer's instruction or physician's direction;
    e. Have up-to-date first aid and emergency supplies that are kept in a closed space inaccessible to children. Transportable first aid kits are 1) available in vehicles used by the program to transport children, and 2) taken on walks or outings outside program premises. First aid kits and supplies are restocked after use; and
    f. Prohibit smoking, alcohol, and drugs on premises or when children are in transit while in care.

Rationale

Although most of these recommendations are in place across current regulatory sets, they are in different sections and vary in specificity and language used. Creating a baseline would streamline regulations and promote consistency in health policies and practices across programs. Finally, many of the recommendations are consistent with the health and safety requirements for programs receiving Child Care and Development Fund (CCDF) funding. Including these requirements in baseline licensing regulations will facilitate access to this key source of funding.

Specific rationale is described by recommendation below:

- Recommendation 1a. Programs receiving CCDF funds must engage in practices that prevent and control infectious diseases. By creating a health policy specific to the program, staff and families will have a common understanding of the program's approach and policies.
- Recommendation 1b. Child health records assist programs in understanding the specific needs and medical history of children in order to provide appropriate care (e.g., preventative health needs, chronic health conditions that need care plans, allergies).[66] *Caring for Our Children Basics* recommends programs have confidential files for each child that include initial and updated health care assessments that are completed and signed by the child's primary care provider, a health history provided by the parent/guardian at admission, and a medication record (9.4.2.1). Consent for emergency medical care should be obtained from families upon entry to the program.
- Recommendation 1c. Under health and safety requirements, CCDF programs must engage in practices that prevent and control infectious diseases, including immunization. It also states that there must be a grace period for homeless children and children in foster care to comply with immunization requirements.[67] Immunizations are part of child health records and are important for protecting a child's health and the health of other children and adults in a child care program, decreasing the risk of dangerous diseases that can cause illness or death.[68]
- Recommendation 1d. Medication administration policies and practices are important to ensure a child receives the correct medication, in the right dosage, that other children do not receive medication meant for another child, and that parental consent is obtained for medication administration at the program.
- Recommendation 1e. Availability of first aid kits ensures swift and timely responses to medical emergencies.
- Recommendation 1f. These policies reduce children's risk of exposure to environmental toxins.

[66] California Childcare Health Program. (n.d.). *Health and safety notes: Maintaining child health records in child care settings*. University of California, San Francisco. https://cchp.ucsf.edu/sites/g/files/tkssra181/f/recorden081803_adr.pdf

[67] US Code (42 USC § 9858c)c(2)(I) Health & Safety Requirements (I).

[68] Stanford Children's Health. (n.d.). *Why childhood immunizations are important*. https://www.stanfordchildrens.org/en/topic/default?id=why-childhood-immunizations-are-important-1-4510

Regulatory Area:

Health – Pets and Animals

The presence of pets and other animals can have benefits for children in child care programs, but care must be taken to avoid risks associated with them, such as germs, biting, and allergies.[69]

Recommendations

1. All programs should follow Centers for Disease Control and Prevention (CDC) recommendations to reduce health and injury risks when pets and other animals are present, which include:[70]
    a. Not having reptiles, amphibians, poultry, rodents, or ferrets with children under 5 years of age;
    b. Consulting with parents to determine special considerations for children who have allergies, asthma, or other illnesses;
    c. Making sure all animals have appropriate and regular veterinary care, and proof of rabies vaccination for dogs and cats, according to local or state requirements;
    d. Supervising children's contact with animals and not allowing children to put their hands or objects (e.g., pacifiers) in their mouth while around animals;
    e. Washing hands with water and soap after handling animals, their food, or their habitats (e.g., cages, terrariums, aquariums, water bowls, and toys);
    f. Cleaning and disinfecting all areas where animals have been; and
    g. Avoiding cleaning tanks, feeders, water containers, and other equipment in sinks or areas where food is prepared, served, or eaten.

Rationale

Many of the recommended items are current regulation in homes and centers. Having a baseline set of recommendations would make it consistent across programs and ensure children are kept safe and healthy when animals and pets are in a program. Requiring these regulations across any licensed child care program is important to reduce health risks (e.g., allergies, germs) and safety risks (e.g., biting) that are inherent with pets and other animals.

---

[69] eXtension Alliance for Better Child Care. (2019, August 15). *Choosing, introducing, and caring for pets in child care.* https://childcare.extension.org/choosing-introducing-and-caring-for-pets-in-child-care/; Centers for Disease Control and Prevention. (n.d.). Animals in schools and daycares. https://www.cdc.gov/healthy-pets/schools-daycares/index.html

[70] Centers for Disease Control and Prevention. (n.d.). *Animals in schools and daycares.* https://www.cdc.gov/healthy-pets/schools-daycares/index.html

Regulatory Area:

Health – Prevention and Control of Infectious Diseases

Preventing and controlling infectious disease promotes child health and reduces risk of illness, long-term complications from illness, and death.

Recommendations

1. All programs should:
    a. Have a routine schedule of cleaning, sanitizing, and disinfecting materials. Children should not be near products used in these activities;
    b. Incorporate hand-washing policies that clearly define when children should wash hands (before meals, after toilet use) and how (using soap and running water). Hand sanitizer use must be supervised if a child is under 6 years old;[71]
    c. Have clear policies for when a child is ill: separating them from others, cleaning and sanitizing items they have touched, and notifying the child's family; and
    d. Have procedures in place to notify families and local/state health authorities of instances of illness and communicable disease within the program.

Rationale

Current Indiana child care regulations include most of the recommended components above, but the information is dispersed across different headings/sections, is duplicative, and contains different definitions. Preventing and responding to communicable diseases is important for all children and staff, and a baseline used across programs would streamline this language to focus on the most critical practices, which are informed by recommendations from *Caring for Our Children Basics*.[72] Additionally, federal regulations mandate that states create health and safety requirements for programs on the prevention and control of infectious diseases.[73]

---

[71] Centers for Disease Control and Prevention. (n.d.). *Hand hygiene in schools and early care and education settings.* https://www.cdc.gov/clean-hands/prevention/about-hand-hygiene-in-schools-and-early-care-and-education-settings.html

[72] Early Learning & Knowledge Center. (2022). *Caring for Our Children Basics. Administration for Children and Families.* https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/caring-our-children-basics

[73] US Code (42 USC § 9858c)c(2)(I) Health & Safety Requirements (I).

Regulatory Area:

Health – Safe Sleep Practices and Rest

Safe sleep practices protect children by preventing serious illness, injury, or death (e.g., Sudden Infant Death Syndrome [SIDS]). Policies addressing sleep equipment and bedding help protect the safety of children and prevent the transfer of disease.

Recommendations

1. All programs should follow "Safe Sleep Practices and Rest," explicitly including state regulations that follow American Academy of Pediatrics (AAP) recommendations[74] for reducing the risk of SIDS as follows:
    a. Staff place infants on their backs in their cribs for sleeping;
    b. Infants do not share sleep space;
    c. Infants sleep in a crib, bassinet, or portable play yard with a firm, flat mattress and a fitted sheet; and
    d. Loose blankets, pillows, stuffed toys, bumpers, and other soft items are kept out of the sleep space.
2. All programs should implement the following practices:
    a. Providing children their own bed, cot, mat, or sleeping bag (older children);
    b. Providing periods of sleep, rest, or quiet time during the day;
    c. Ensuring equipment (cribs, portacribs, cots) meets U.S. Consumer Product Safety Commission standards, have not been recalled, and that they have a firm-fitting mattress or pad made of waterproof materials; and
    d. Ensuring staff have enough space to move between sleep furniture and equipment (e.g., cribs).
    3. All programs should have regulations requiring the cleaning and sanitation of cribs, cots, and bedding daily, between use if two part-time children use it, or immediately if wet or soiled.

Rationale

Federal regulations require that programs support the prevention of SIDS and the use of safe sleeping practices.[75] Currently, all settings must follow safe sleeping practices and the section describes penalties for not doing so in Indiana Administrative Code. While IAC includes regulations on implementing safe sleep practices, these are often under different section titles and have slightly different language. In some cases, practices such as ensuring infants sleep on their backs and without soft items are not in every IAC set. Because the risk of SIDS does not vary by location, these practices should be explicitly applicable to all programs.

Similarly, practices around sleep and rest were inconsistent across regulatory sets, with center regulations delving into some items that were too prescriptive. The recommendations reduce the number of rules in centers and provide a consistent baseline across all programs that are anchored in guidance from *Caring for Our Children Basics* and the Centers for Disease Control.

---

[74] American Academy of Pediatrics. (n.d.). *Safe sleep for babies.* https://www.aap.org/en/patient-care/safe-sleep/

[75] US Code (42 USC § 9858c)c(2)(I) Health & Safety Requirements (II).

Safety

Emergency Preparedness

Equipment Maintenance and Safety

Water Safety

Reporting Child Abuse, Injury, and Neglect

Regulatory Area:

Safety – Emergency Preparedness

To keep children and staff safe, every program should have policies and procedures in place in the case of an emergency (natural or man-made) to reduce harm to both the children and staff members.

Recommendations

1. All programs should have the following:[76;77]
    a. A written policy that explains the emergency plans and evacuation procedures the program would adhere to in the event of an emergency including:
        - Evacuation emergencies (e.g., gas leak or fire)
        - Shelter-in-place emergencies (e.g., tornado)
        - Lockdown emergencies (e.g., violent or hostile intruder)
        - Lockout emergencies (e.g., dangerous person reported in the area) and children, staff, or volunteers need to be brought back inside and the building secured;
    b. A pre-set schedule for practicing an evacuation, fire drill, and/or lockdown drills (e.g., twice a year or once a quarter):
        - A program should provide documentation annually showing that they conducted the necessary drills;
    c. A policy and procedure for notifying parents in advance of when a drill will occur; and
    d. A written plan for how the program could accommodate children who are multilingual learners and children with disabilities, special health care needs, or developmental delays.

Rationale

A pre-determined schedule for practicing evacuation procedures, shelter-in-place, or lockdown drills ensures that program staff will be prepared in the event of a real emergency. Practicing drills also ensures that children will be comfortable with the process and procedures. However, children should only engage in drills that are developmentally appropriate. If a drill is intense or "realistically simulates hostile or harmful events,"[78] then they should not participate. Further, parents or guardians should be notified in advance if an evacuation drill will be taking place.

Federal regulations require that health and safety standards should include emergency preparedness so that programs and staff are prepared to keep children safe in the event of a natural disaster or other emergency. The federal regulations recognize that ensuring the safety of children during or after an emergency "necessitates planning in advance by State/Territory agencies and child care providers."[79]

---

[76] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC)*, Chapter 9: Administration, 9.2 Policies. https://nrckids.org/CFOC/Database/9.2.4.5

[77] Child Care Aware® of America. (2020). Child Care Benchmark Licensing Project. https://info.childcareaware.org/hubfs/ChildCareBenchmarkLicensingProject-FINAL-11022020.pdf?hsCtaTracking=61cf9472-d1a4-437d-ad3d-7e73bf19bc-7d%7C5428138c-ce9a-471f-bce5-0ec3b735e7eb

[78] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC)*, Chapter 9: Administration, 9.2 Policies. https://nrckids.org/CFOC/Database/9.2.4.5

[79] Department of Health and Human Services, Administration for Children and Families. (2016, September 30) *Federal Register, 81(190),* 67484, *Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67456). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

Under current IAC, every early childhood setting is required to meet some type of emergency preparedness requirement. However, the exact language is different depending on the auspice. Setting one consistent expectation across all programs and aligning with federal regulations will ensure the process is clear for all programs and consistent with national standards of best practice. This universal expectation will also support licensing consultants in being consistent in their enforcement and support across all programs.

Regulatory Area:

Safety – Equipment Maintenance and Safety

Educational equipment both indoor and outdoor should be safe and age-appropriate with proper maintenance conducted as necessary to minimize any safety concerns.

Recommendations

1. Any program type that offers overnight care should be required to have a night-care schedule of activities.
2. Programs should adhere to a set of standards regarding the safety of equipment and materials that include the following:
    a. Clean and sanitize all materials at least once a week;
    b. All indoor gross motor equipment should meet the Consumer Product Safety Commission's guidelines;
    c. All equipment should be free from hazardous objects or materials (e.g., toxic paint); and
    d. Any educational materials used for infants should be easy to clean and, in the case of pacifiers, not hanging from an infant's neck.

Rationale

The recommendations above amend current regulations by significantly reducing any duplicative requirements or deleting those that were not measurable or enforceable.

In any early education program, equipment should be safe, age-appropriate, as well as "sturdy, in good condition, safe to use, and used only as intended by the manufacturer."[80] Any hazardous items that are raised above the ground, sharp, present choking or strangulation hazards, or could pose any risk of entrapment should be prohibited from being present at an early care and education program.[81]

Policies about daily (or night-time) activities are important for clarifying how a caregiver plans to care for all children or accommodate their needs depending on their age or ability.[82]

---

[80] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), Chapter 5: Administration, 5.3 General Furnishings and Equipment.* https://nrckids.org/CFOC/Database/5.3.1.1

[81] Ibid.

[82] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), Chapter 9: Administration, 9.2 Policies.* https://nrckids.org/CFOC/Database/9.2.1.1

Regulatory Area:

Safety – Water Safety

Regulations on water safety may not apply to every program, but if a swimming or wading pool or any other source of open water is on the premises, having clear safeguards in place to protect children is applicable to the licensing process. Further, if a program chooses to take a field trip to a private or public body of water or offer access to a water table, then there are also health and safety considerations.

Recommendations

1. All programs should follow baseline regulations about water safety that focus on supervision and hygiene, which are crucial to child and staff safety. Recommendations on the components that should apply based on national standards of best practice are depicted in **Table 2**.

Table 2: Recommended Licensing Regulations, by Type of Water Access
Swimming or Wading Pool (either for a field trip or on the premises)
Supervisory Ratio
Parental Permission
Physical Cleanliness
Pool Equipment and Chemical Storage
Flotation Devices Present
Staff Qualifications
Locked Fence & Pool Cover
Touch Supervision (aged 0-5)
Body of Water (e.g., field trip to a lake)
Parental Permission
Flotation Devices Present
Touch Supervision
Supervisory Ratios
Water Table
Physical Cleanliness
Staff/Child Hygiene

Rationale

Drowning incidents can occur quickly, even in familiar surroundings, in as little as two inches of water, and/or when a child has been out of sight for less than five minutes. Having plans in place to prevent a water-related incident is crucial to protect young children. When near bodies of water or pools, constant and active supervision is crucial, with specific ratios and safety measures in place depending on the age of the children involved.[83] Clear pool safety rules should be posted and followed, with attention paid to factors like nonslip surfaces and equipment safety and storage. Recommendations from the American Academy of Pediatrics and Centers for Disease Control and Prevention underscore the importance of swimming lessons, "touch supervision," proper fencing, and adult vigilance in preventing water-related accidents.[84] Indiana has many of these in current administrative code, and this should be supplemented with language about the necessity of "touch supervision,"[85] defined as having a caregiver within arm's length when a child is interacting with any body of water (e.g., wading pool, tub, sink, or toilet).

For programs where children engage with a swimming pool or built-in wading pool, there must be at least one individual who has a certification in age-appropriate CPR, water safety, and an American Red Cross advanced lifesaving certificate.[86]

[83] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), 2.2 Supervision and Discipline*. https://nrckids.org/CFOC/Database/2.2.0.4

[84] Ibid.

[85] Ibid.

[86] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), 1.4 Professional Development/Training*. https://nrckids.org/CFOC/Database/1.4.3.3

Further, standing water such as in a water table can also be a source of infectious disease or illness. Therefore, regulations should address proper hygiene. For water tables, it is essential to ensure fresh water is used and regular cleaning and disinfection are carried out. Staff and children should wash hands before and after play, and precautions should be taken to prevent drinking from the water table.[87]

[87] National Resource Center for Health and Safety in Child Care and Early Education. (n.d.). *Caring for Our Children (CFOC), 6.2 Play Area/Playground Equipment*. https://nrckids.org/CFOC/Database/6.2.4.2

Regulatory Area:

Safety – Reporting Child Abuse, Injury, and Neglect

Caregivers in child care programs should be able to recognize symptoms (physical or emotional) that indicate abuse or neglect.[88]

Recommendations

1. All programs should be subject to statute and regulations governing two subjects:
    a. The investigation of child abuse or neglect within the specific early learning program; and
    b. Procedures for reporting suspected child abuse or neglect (including injury, death, illness, or any other emergency event).

Rationale

The recommendation above does not suggest any significant modification to what is already in place across early childhood programs. Instead, it focuses on consolidating five sets of regulations that apply to homes, centers, and voucher programs to two.

State law requires that caregivers report suspected "physical abuse, sexual abuse, child neglect, or child exploitation."[89] Federal requirements also address this subject, requiring the state to have a standard regulation that also adheres to federal CCDF requirements to craft health and safety standards regarding the recognition and reporting of child abuse and neglect.[90]

---

[88] National Resource Center for Health and Safety in Child Care and Early Education. (2018, May 29). *Caring for Our Children (CFOC), Chapter 3: Health Promotion and Protection, 3.4 Health Protection in Child Care.* https://nrckids.org/CFOC/Database/3.4.4.1

[89] Justia. (2022). *Indiana Code Title 31. Family Law and Juvenile Law § 31-33-5-2.* https://law.justia.com/codes/indiana/2022/title-31/article-33/chapter-5/section-31-33-5-2/

[90] Department of Health and Human Services, Administration for Children and Families. (2016, September 30). *Federal Register, 81(190), 67484, Rules and Regulations, 45 CFR Part 98, RIN 0970–AC67, Child Care and Development Fund (CCDF) Program.* (pp. 67486). https://www.govinfo.gov/content/pkg/FR-2016-09-30/pdf/2016-22986.pdf

Transportation

Transportation

Regulatory Area:
Transportation

Transportation regulations support the safe movement of young children in vehicles, and preparedness to respond should a health and safety issue arise during transport.

Recommendations

1. All programs should have baseline regulations for transportation of children, including:
    a. Required written or digital documentation of parental permission for transporting children, including acknowledgement of program responsibility for safety of children during transport;
    b. Qualifications for drivers that include:
        - Driver who is 18 years or older, with a valid driver's license for type of vehicle operated and a safe driving record;
        - No use of alcohol, drugs, or substances that impair driving abilities;
        - No tobacco use while driving;
        - No medical condition that could impact driving, supervision, or evacuation capability; and
        - Valid pediatric CPR and first aid certificate if transferring children with no other staff;[91]
    c. Child passenger restraint systems that are developmentally appropriate (e.g., safety seat, booster seat), installed and used according to manufacturer's instructions, and have not been recalled. Special considerations for school buses include accommodations for wheelchairs (use of four tie-down according to manufacturer's instructions for a wheelchair, and child secured by a three-point restraint system);[92]
    d. Protocols so children are not left in vehicles unattended, including: locking the vehicle when not in use, taking head counts of children before and after transport, and never leaving a child unattended in a vehicle;[93]
    e. Emergency preparedness, including:
        - Emergency medical authorization and emergency contact numbers are available to staff during transport;
        - First aid equipment is available in the vehicle;[94]
    f. Liability insurance for all passengers;
    g. Vehicles that are licensed and maintained, have locks, and receive visual inspection from staff to ensure the interior of the vehicle is clean and free of obstructions on the floors, seats, and windows; and

---

[91] Early Childhood Learning & Knowledge Center. (2022). *Qualifications: Drivers.* U.S. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/qualifications-drivers

[92] Early Learning & Knowledge Center. (2022). *Caring for Our Children Basics, Child Passenger Safety.* Administration for Children and Families, U.S. Department of Health & Human Services. https://eclkc.ohs.acf.hhs.gov/health-services-management/caring-our-children-basics/child-passenger-safety

[93] Early Learning & Knowledge Center. (2022). *Caring for Our Children Basics: Interior temperature of vehicles.* U.S. Department of Health & Human Services.

[94] Requirement for first aid kit in vehicles is covered in the "Health" section.

h. Parameters for how and when children are transported: loading/unloading children at curbside with car turned off, locking vehicle doors when in motion, passenger load at or below manufacturer's capacity, children not sitting in the front seat, and comfortable air temperature.

Rationale

States and territories are required to address the health and safety of children during transportation to receive CCDF funding.[95] Transportation practices are important for the safety of all children, and practices should be in place no matter the program. Currently, IAC for homes and centers contains the bulk of these recommendations. For centers, this information is often duplicated in separate sections for center-owned or -leased vehicles (470 IAC 3-4.7-72) and other vehicles (470 IAC 3-4.7-73). Combining and condensing this language would reduce the number of rules, yet still adhere to minimum health and safety best practices in transportation. Further explanation of recommendations by item are listed below:

- **Recommendation 1a.** Parents should have the right to understand and provide approval for when and how programs transport children in vehicles.
- **Recommendation 1b.** Safe drivers who have the capacity to attend to and respond to driving conditions as well as provide supervision to children are important for the safety of all vehicle occupants and others on the road. Knowledge of pediatric CPR and first aid enables immediate provision of emergency care if needed. Language on minimum age of driver reflects current regulations for homes and voucher recipients and reduces the minimum age from 21 to 18 for centers.
- **Recommendation 1c.** Proper passenger safety restraints for children are essential to support minimal injury to children should a car collision occur.
- **Recommendation 1d.** Active supervision and checks to ensure children are never unintentionally left in a vehicle prevents harm or death due to overheating or freezing in a vehicle.[96]
- **Recommendation 1e.** Access to information enables staff to respond quickly to any injuries and to inform parents as soon as possible.
- **Recommendation 1f.** Liability insurance ensures coverage is available should there be a vehicle collision.
- **Recommendation 1g.** Vehicles should be well-maintained to ensure the vehicle is safe to operate and that the internal space is well-ventilated, safe, and comfortable for children.
- **Recommendation 1h.** These parameters ensure that children are protected while entering and exiting a vehicle (i.e., not using doors next to traffic lanes), the vehicle is not overcrowded, and that children do not have opportunities to open a car door.

---

[95] Electronic Code of Federal Regulations. (n.d.). 45 CFR § 98.41 - *Transportation*. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-98/subpart-E/section-98.41

[96] National Center on Early Childhood Quality Assurance. (2020). *CCDF health and safety requirements brief #8: Transportation of children*. https://childcareta.acf.hhs.gov/sites/default/files/new-occ/resource/files/transportation_brief_8_2020.pdf

Process Recommendation: Variances

No set of licensing regulations can envision every scenario in a child care program. As such, the state should provide early learning programs with the option to submit alternative plans for consideration by the state. These would only apply if written regulations could 1) not be reasonably met or 2) be shown to not be applicable. This recommendation provides programs the opportunity to demonstrate modifications currently in use or modifications that could be implemented to maintain health and safety for children. The opportunity to submit plans for consideration by the state acknowledges that child care businesses operate in their own unique contexts while still retaining a commitment to the health and safety of children.

Core Child Care Licensing Regulations Across All of Indiana's Early Childhood Settings

Core Child Care Licensing Regulations Across All of Indiana's Early Childhood Settings

1. Background Screening

1.1. National Criminal History Check

1.1.1. Background check process should reflect what is required for any program that accepts vouchers including:[1]

1.1.1.a. FBI fingerprints for a national criminal history background check for all employees and volunteers and anyone 18 years and older who resides in a program that is residential.

1.1.1.b. Report to the state any criminal history of the staff or volunteers.

1.1.1.c. Conduct a statewide criminal history for the provider, anyone over 18 living in the home, and employees and volunteers at the facility.

1.1.1.d. State Central Registry Check.

1.1.2. Allow temporary employment or voucher payments while waiting on the national criminal history background check, if the individuals have already submitted their fingerprints and conducted a local criminal history and there were no findings from the local criminal history background check.

2. Definitions

2.1. Defining Caregivers. Qualified Caregiver is an individual who is responsible for and directly engaged in supervising and implementing activities for children, and has met the qualifications outlined in Section 3.1.

2.2. As used in this document:

2.2.1. Residential refers to a facility in which an individual resides.

2.2.2. Non-residential refers to a facility in which an individual does not reside.

3. Qualifications

3.1. Minimum qualifications for a qualified caregiver in a child setting are:

3.1.1. High-school degree or equivalent and;

3.1.2. Passing score on competency assessment designated by role.

4. Training

4.1. Pre-Service and Annual Training (annual training means the training should occur once every calendar year)

4.1.1. Developmentally appropriate practices to implement positive discipline practices and support cognitive and social emotional development [2]

4.1.2. Parent communication strategies[3]

4.1.3. Recognizing symptoms of illness[4]

4.1.4. Cleaning, sanitation, and disinfection procedures[5]

4.1.5. Safe sleep practices[6]

4.1.6. Staff occupational health and safety practices (e.g., Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations)[7]

4.1.7. Procedures for an emergency and disaster preparedness; response procedures should a child be injured[8]

4.1.8. Child abuse detection, prevention, and reporting responsibilities[9]

4.1.9. Basic First Aid[10]

---

[1] Modified from 470 IAC 3-18-14 Criminal history information, 470 IAC 3-18-16 State central registry check, and IC 12-17.2-3.5-12 National criminal history background check; temporary eligibility

[2] Modified from 470 IAC 3-4.7-35 In-service staff training

[3] Modified from 470 IAC 3-4.7-32 Staff orientation

[4] Modified from 470 IAC 3-4.7-35 In-service staff training

[5] Modified from 470 IAC 3-4.7-35 In-service staff training

[6] Modified from IC 12-17.2-4-4.1 Safe sleeping practices; violations; penalties

[7] Modified from 470 IAC 3-4.7-32 Staff orientation

[8] Modified from 470 IAC 3-4.7-32 Staff orientation

[9] Modified from 470 IAC 3-4.7-32 Staff orientation

[10] Modified from 470 IAC 3-4.7-33 Basic first aid training

4.2. Orientation Training should occur within the first 90 days a staff member begins their employment and include: [11]

4.2.1. Food safety and handling
4.2.2. Daily schedules, routines, and transition procedures
4.2.3. Special needs inclusion policies
4.2.4. Training to the needs of children under their care
4.2.5. The center's confidentiality policy

5. Personnel Screening

5.1. Drug Test [12]

5.1.1. The provider shall, at no expense to the verifying agency, provide to the verifying agency a copy of drug testing results for the following: (1) The provider. (2) All individuals at least eighteen (18) years of age living in a facility where child care is provided. (3) All employees and volunteer caregivers at the facility where child care is provided.
5.1.2. Drug tests must meet the following criteria: (1) Urine panel that tests for amphetamines, cocaine, opiates, phencyclidine, and THC metabolites. (2) Urine collection that is consistent with chain of custody guidelines established by the DOT. (3) Specimen processing by a laboratory certified by the Substance Abuse and Mental Health Services Administration (SAMHSA). (4) Evaluation of urine panel results by a certified medical review officer using positive cutoffs established by the DOT.
5.1.3. The verifying agency shall keep drug test results confidential and will not use drug test results for any other purpose other than for this rule.

5.2. Medical Requirements

5.2.1. Any staff or volunteer who has direct contact with children should upon employment provide documentation of:
5.2.1.a. A physical examination by a physician or nurse practitioner that states there is no known communicable disease in an infectious state and no physical or mental conditions that would interfere with assigned child care duties.
5.2.1.b. Tuberculosis screening through Interferon Gamma Release Assay (IGRA) or Mantoux tuberculin test. Persons with a history of tuberculosis or a positive IGRA or Mantoux test must have an annual health assessment, including a symptom screening for tuberculosis documented by a health professional. For care provided in residential settings, this testing applies to all family members over eighteen (18) years of age.

6. Supervision

6.1. Child Supervision. All children shall be under the direct supervision of a responsible caregiver at all times.[13]
6.2. Staffing Supervision Policies. Direct supervision of children is allowed after the individual has:
6.2.1. Cleared background check requirements. Any adult who has not completed background check components must be supervised by someone who has had a qualifying background check result within the past five (5) years.
6.2.2. Completed training in: pediatric first aid and CPR, safe sleep practices, standard precautions to prevent communicable disease, poison prevention, and shaken baby syndrome/abusive head trauma. If not, they must be supervised until training is completed.
6.3. If only one (1) adult is supervising a group of children, that adult has means available to communicate with other caregivers and summon assistance without leaving children unattended (non-residential; residential with two (2) or more staff directly supervising children). [14]
6.4. At least two (2) adults are present during all hours of operation (non-residential). [15]
6.5. There is one identified individual who serves as the operational point of contact for a child care site, with authority and knowledge to implement program protocols, meet with licensing, respond to emergencies, and communicate with parents and staff on program operations.
6.6. Staffing includes a qualified caregiver for each group of children and a primary caregiver is assigned to each child.

[11] Modified from 470 IAC 3-4.7-32 Staff orientation
[12] Modified from 470 IAC 3-18-15 Drug testing
[13] Modified from 470 IAC 3-4.7-48 Child/staff ratios and supervision and 470 IAC 3-1.1-36.5 Child to staff ratio
[14] Modified from 470 IAC 3-4.7-48 Child/staff ratios and supervision
[15] Modified from 470 IAC 3-4.7-48 Child/staff ratios and supervision

6.7. For night care staffing there shall always be at least two (2) caregivers on duty at all times regardless of the child/staff ratio. Caregivers counted for purposes of meeting child/staff ratio requirements shall be awake at all times.[16]

6.8. Providers make reasonable effort to provide continuity of care for children under thirty (30) months of age.[17]

6.9. *Field Trips.*

6.9.1. Caregivers shall account for all children before, during, and after field trips.

6.9.2. The provider shall obtain written or digital parental permission for each child prior to participation in a field trip.[18]

6.10. *Naps.* During the rest period for children toddler age and older, caregivers may supervise children at fifty percent (50%) of the required child/staff ratio provided that: (1) the required child/staff ratio is maintained on the premises; (2) required caregivers are immediately accessible; and (3) a minimum of fifty percent (50%) of the children in the class are asleep. The fifty percent (50%) reduction in child/staff ratios does not apply to infants.[19]

7. Ratio, Group Size, Grouping, and Personal Space

7.1. The following definitions are used when describing ratios:

7.1.1. O-11 months ("infant" or "less than one-year-old")

7.1.2. 12-23 months (one-year-old)

7.1.3. 24-35 months (two-year-old)

7.1.4. 36-47 months (three-year-old)

7.1.5. 48-59 months (four-year-old)

7.1.6. 60 months (five-years-old or older)

7.2. Adult to child ratios are as follows:

Sites with less than 16 children with mixed ages		Sites with more than 16 children with single-age classrooms	
Two children younger than 16 months per adult	1:4	0-12 months	1:4
One child younger than 16 months	1:6	13-23 months	1:5
No children younger than 16 months	1:8	24-35 months	1:5
No children younger than 3	1:10	3-year-olds	1:10
		4-year-olds	1:12
		5-year-olds	1:15

7.2.1. In cases where a site with less than 16 children serves only one age grouping of children (e.g., three-year-olds) the site may choose to adhere to the single-aged ratios of larger sites. Similarly, larger sites with mixed-aged classrooms may choose to adhere to mixed-age ratios of smaller sites in individual classrooms.

7.3. Maximum group sizes are as follows:

Sites with 16 children or less with mixed ages		Sites with more than 16 children with single-age classrooms	
No children younger than 16 months	16	0-12 months	8
No children younger than 3	16	13-23 months	10
One child younger than 16 months	16	24-35 months	10
Two children younger than 16 months	16	3-year-olds	20
		4-year-olds	24
		5-year-olds	30

[16] Modified from 470 IAC 3-4.7-151 Night care staffing

[17] Modified from 470 IAC 3-4.7-51 Implementation of continuity of care

[18] Modified from 470 IAC 3-4.7-71 Field trips

[19] Modified from 470 IAC 3-4.7-53 Night care program and equipment

7.4. Adult to child/ratios must be maintained at all times.
7.5. Only qualified caregivers should be counted in the ratio.
7.6. All children in the setting who require supervision by an adult, regardless of whether they are related to the caregiver, should be included in the ratio count of children.
7.7. Each child care room/area shall have a minimum of thirty-five (35) square feet of usable indoor play space per child at all times. Infant and toddler rooms must have fifty (50) square feet of usable indoor play space per child at all times.
7.8. Children who have a birthday during the program year can stay with their current age cohort until a new classroom can be assigned or August 1st of the program year, whichever comes first.

8. Behavior & Guidance

8.1. Discipline/Prohibited Practice/Positive Guidance

8.1.1. Definitions

8.1.1.a. "Corporal punishment" means any kind of punishment inflicted on a child's body.
8.1.1.b. "Discipline" means the ongoing process of helping children to develop self-control for self-management while protecting and maintaining the integrity of the child.
8.1.1.c. "Punishment" means the use of negative consequences to stop unwanted behavior.

8.1.2. Discipline and Prohibited Practices[20]

The program shall formulate a program-wide written discipline policy and distribute the policy to parents and staff. These policies include practices that prevent the suspension and expulsion of children (see ii of this section).

8.1.2.a. Discipline practices should emphasize redirection and reinforcement of positive behaviors as discipline strategies and to guide children's behavior.
8.1.2.b. The following behavior shall be prohibited by all direct child care providers: (1) inflicting corporal punishment in any manner upon a child's body; (2) cruel, harsh, or unusual punishment; (3) withdrawal or the threat of withdrawal of scheduled meals or snacks, rest, or bathroom opportunities; (4) public or private humiliation, yelling, or abusive or profane language; (5) associating disciplinary action or rewards with rest; (6) associating disciplinary action with food or use food as a reward; (7) associating disciplinary action with or humiliating a child in regard to toileting; (8) isolating a child in an area where they cannot be seen or supervised.
8.1.2.c. Caregivers shall not: (1) using time out for any child less than three (3) years of age; (2) use time out for any purpose other than to enable the child to regain control; (3) physically restrain or restrict movement of children except: (A) when it is necessary to ensure their own safety or that of others; and (B) only for as long as necessary to control the situation.

8.2. Activities and Programming[21]

8.2.1. Activities to Support Development.

8.2.1.a. The caregiver shall provide activities according to the age, developmental needs, interests, and number of children in care while including both active and quiet play, which may consist of safe, age-appropriate toys, games, and equipment for both indoor and outdoor play.
8.2.1.b. Opportunity shall be provided for children to play outdoors daily except when: (1) the severity of the weather poses a safety or health hazard; or (2) when there is a health-related reason documented by a parent, legal guardian, or physician for a child to remain indoors.
8.2.1.b.1. Activities and Programming - Infants and Toddlers. After discussion with the parent or legal guardian of each infant or toddler in care, caregiver shall: (1) establish flexible routines for naps, feedings, diapering, and toilet training; and (2) provide opportunities for play and exploration of the environment.

8.2.2. Screen Time. Children under age two do not engage in electronic device activities, unless it is a video chat. Children age two or above have less than two hours a day of screen time, with an exception that television, DVD, or video viewing is limited to one hour a day.

---

[20] Modified from 470 IAC 3-1.1-41 Discipline, 470 IAC 3-4.7-55 Inappropriate discipline, and 470 IAC 3-4.7-56 Discipline documentation
[21] Modified from 470 IAC 3-1.1-38 Activities for healthy development and 470 IAC 3-1.2-4 (Infant/Toddler) Activities for healthy development

9. Family Engagement

9.1. Unscheduled visits by parents and guardians should be permitted any time a child is enrolled in care with a program and parents should be notified of this right.[22]

9.2. Communication with parents: Programs shall conduct regularly scheduled conversations with parents about a child's progress, development, and (as applicable) challenges, including any updates to the child's health record. These conferences or conversations should occur at least every six months if a child is less than six years.[23]

9.3. Enrollment documentation:

9.3.1. Upon enrollment, the program shall provide in writing the following information[24]:

9.3.1.a. Provisions for emergency medical care

9.3.1.b. Provisions for treatment of illness

9.3.1.c. Policy regarding visits, field trips, or excursions off the premises.

9.3.2. Upon child's enrollment, the program will procure a statement that explains who the child's parent(s), legal guardian(s), and other authorized people are, and to whom the child can be released.[25]

9.3.3. All relevant legal documents, court orders, etc., shall be collected and filed during the enrollment process and caregivers/teachers should comply with court orders and written consent from the parent/guardian with legal authority.[26]

10. Environment (Facilities, Physical Environment)

10.1. General

10.1.1. General building safety

10.1.1.a. The building or parts thereof used for child care purposes shall be structurally sound and shall at all times be maintained in a clean, safe, and sanitary condition and be in a good state of repair.[27] Building meets any building code requirements set forth by the state.

10.1.1.b. The program shall ensure that no conditions exist in the home or on the grounds where child care services are provided that would endanger the health, safety, or welfare of the children.[28]

10.1.2. Interiors

10.1.2.a. All interior surfaces, equipment, materials, furnishings, and objects with which children will come in contact shall be well maintained, in a clean and sanitary condition, and of nontoxic durable construction.[29]

10.1.2.b. Interior finish, including walls and ceilings, of the child care center shall comply with the rules of the FPBSC under 675 IAC.[30]

10.1.3. Cleaning

10.1.3.a. Site is cleaned daily.[31]

10.1.3.b. Staff shall not do major cleaning, except for spills after meals and art projects, while children are present in the area being cleaned.[32] Caregivers shall not care for children in areas that are being remodeled, repaired, or painted.[33]

10.1.4. Doors[34]

10.1.4.a. The program shall make all interior room and closet doors such that children can open the doors from the inside.

10.1.4.b. The program shall not provide locking or latching devices on child bathroom doors.

10.1.4.c. All interior locked doors shall be designed to permit opening by the staff. The key or other opening device shall be readily accessible to staff.

10.1.4.d. Automatic door closures must be adjusted properly.

---

[22] Modified from IC 12-17.2-6-15 Unscheduled visits by parents and guardians and 470 IAC 3-1.1-37 Requirements for admission to the home

[23] Modified from 470 IAC 3-4.7-18 Parent communication

[24] Modified from 470 IAC 3-4.7-16 Enrollment

[25] Modified from 470 IAC 3-4.7-16 Enrollment

[26] Modified from 470 IAC 3-4.7-17 Admission, discharge, arrival, and departure policies

[27] Modified from 470 IAC 3-4.5-4 Buildings, grounds, equipment, furnishings, materials and supplies

[28] Modified from 470 IAC 3-1.1-45 General environment (a)

[29] Modified from 470 IAC 3-4.5-4 Buildings, grounds, equipment, furnishings, materials, and supplies

[30] Modified from 470 IAC 3-4.7-99 Building maintenance

[31] Modified from 470 IAC 3-4.7-99 Building maintenance (i)

[32] Modified from 470 IAC 3-4.7-99 Building maintenance (j)

[33] Modified from 470 IAC 3-4.7-99 Building maintenance (b)

[34] Modified from 470 IAC 3-4.7-108 Door

10.1.5. Furnishings[35]

10.1.5.a. Furnishings and equipment (inside and outside) shall be durable, safe, and scaled to the size of the children.

10.1.5.b. Staff shall not stack tables or chairs in the class room/area while children are present.

10.1.6. Infant Toddler Furnishings[36]

10.1.6.a. Materials and equipment not rated as safe for infants (e.g., mesh play pens, cradles, bean bag chairs) are prohibited in infant rooms.

10.1.6.b. A sanitizable changing table must be present.

10.1.6.c. No one shall use the infant or toddler rooms as throughways.[37]

10.1.6.d. The caregiver shall have stairways guarded by a gate or closed door.

10.2. Bathrooms, Sinks, Water Supply

10.2.1. Toilets and Sinks

10.2.1.a. If toilets and sinks are not child-sized, the program must provide safe, sanitizable steps or platforms for each toilet and sink.

10.2.1.b. In residential settings, at least one (1) flush toilet and a sink are accessible to children on each floor of the site where services are provided.[38]

10.2.1.c. In non-residential settings:

10.2.1.c.1. The site has a minimum of one (1) sink and one (1) flush toilet per fifteen (15) children two (2) years of age and older. When the licensing capacity exceeds sixty (60) children, the center may substitute one (1) urinal for a toilet in the school-age area only.[39]

10.2.1.c.2. In infant/toddler rooms, sinks and toilets are located in a room with a door that opens directly into the toddler room or no more than 10 feet from their room/area.[40]

10.2.1.c.3. For school-age children: (1) Partitions shall separate toilets for school-age children if there is more than one (1) toilet in a room. (2) Stalls used by school age children shall have doors. (3) Children should not use the same restroom/individual stall at the same time.

10.2.1.c.4. Toilet facilities for staff shall be furnished, separate from those facilities used for children. Staff shall not use children's toilets.

10.2.2. Bathroom supplies[41]

10.2.2.a. Toilet paper on a dispenser shall be available and within reach of the children by each toilet.

10.2.2.b. Mild soap shall be available and within reach of the children at each sink.

10.2.2.c. Disposable towels in a dispenser or electrical hand dryers that operate at a maximum temperature of one hundred twenty (120) degrees Fahrenheit shall be within reach of the children by the sinks.

10.2.3. *Bathroom facilities*

10.2.3.a. The provider must seal all hand washing sinks to the wall.

10.2.3.b. The provider must seal all walls and floors in restrooms.

10.2.3.c. All items in the restroom must be sanitizable.

10.2.4. Running water[42]

10.2.4.a. The program shall ensure that the site has hot and cold running water.

10.2.4.b. "Hot water" means water with a temperature of at least one hundred (100) degrees Fahrenheit.

10.2.5. Water supply

10.2.5.a. The center shall maintain a safe and sanitary water supply.

10.2.5.b. If the site uses a private water supply or well instead of a public water supply, the program shall supply written records of current test results indicating that the water supply is safe for

[35] Modified from 470 IAC 3-4.7-111 Indoor furnishings

[36] Modified from 470 IAC 3-4.7-129 Infant room furnishings and 470 IAC 3-4.7-130 Toddler room furnishings

[37] Modified from 470 IAC 3-4.7-143 Infant/toddler rooms; general

[38] Modified from 470 IAC 3-1.1-47 Sanitation

[39] Modified from 470 IAC 3-4.7-113 Bathrooms Sec. 113. (a) and 470 IAC 3-4.7-113 Bathrooms Sec. 113. (b)

[40] Modified from 470 IAC 3-4.7-143 Infant/toddler rooms; general

[41] Modified from 470 IAC 3-4.7-113 Bathrooms

[42] Modified from 470 IAC 3-1.1-47 Sanitation (b) and 470 IAC 3-18-1 General definitions (16)

drinking and is tested annually for compliance with water quality requirements. The water system must meet the water quality and construction standards of the IDEM.[43]

10.2.6. Drinking water facilities

10.2.6.a. Are not to be located in restrooms.

10.2.6.b. Are constructed of impervious, easily cleanable materials and shall be kept clean and in a good state of repair.

10.2.6.c. Drinking fountains, where provided, shall have a sanitary type guarded angle-stream jet head and an adjustable flow regulator.[44]

10.2.7. Plumbing and Sewage Disposal. All plumbing fixtures shall discharge into a public sanitary sewer whenever available within a reasonable distance, or when soil conditions prohibit the construction of an adequate on-site system. All sewage disposal and any sewage treatment system shall meet the requirements of ISDH. All plumbing fixtures shall be in good repair. All plumbing equipment shall meet the requirements of the FPBSC under 675 IAC, ISDH, and IDEM.[45]

10.3. Fire Safety and Prevention

10.3.1. Fire and smoke detection systems

10.3.1.a. A provider providing care in a residential building must have a working electrical or battery-operated smoke detector that is installed to manufacturer's specifications and is located and adjusted to operate reliably in case of smoke in any part of the child care home, including not less than one (1) smoke detector at the top of each stairway and adjacent to all sleeping areas. The alarm should be loud enough to alert all occupants in the child care home.

10.3.1.b. A provider providing care in a nonresidential building must have fire alarm and suppression systems as required by the applicable rule of the fire prevention and building safety commission.[46]

10.3.2. Fire extinguishers. A provider must provide a two and one-half (2½) pound or greater ABC multiple purpose fire extinguisher with valid expiration date that shall be located on each floor of the facility in which child care services are provided and an additional extinguisher located in the kitchen area of the facility.[47]

10.3.3. Exits, hallways, and stairways

10.3.3.a. A facility where a provider operates a child care program must have two (2) exits that: (1) do not require passage through a garage or storage area where hazardous materials are stored; (2) are not windows; (3) are on different sides of the facility; (4) are operable from the inside without the use of a key or any special knowledge using a one-step process; (5) are not locked, chained, bolted, barred, latched, or otherwise rendered unusable.

10.3.3.b. A basement area in which child care services are provided shall have a direct exit at ground level not involving stairs or ramps. The interior staircase serving the first floor is acceptable as the second exit for a basement in which child care services are provided.[48]

10.3.3.c. For programs in residential settings, each room of the program where child care services are provided is required to have at least two (2) means of escape (this may include one (1) window and one (1) door).[49]

10.3.3.d. All portions of the means of egress shall comply with the rules of the FPBSC under 675 IAC.

10.3.3.e. All hallways, stairways, corridors, aisles, and exits must be lighted and free from obstructions at all times.

10.3.3.f. All exterior and interior stairways shall comply with the rules of FPBSC under 675 IAC.

10.3.3.g. Exit signs shall be installed and maintained in accordance with the rules of the FPBSC under 675 IAC.

10.3.3.h. Non-residential settings shall provide emergency lighting in all interior hallways, stairways, and corridors.[50]

---

[43] Modified from 470 IAC 3-1.1-47 Sanitation (b), 470 IAC 3-1.1-28 Initial licensure (a) (6), 470 IAC 3-4.7-114 Water supply and plumbing, and 470 IAC 3-18-1 General definitions

[44] Modified from 470 IAC 3-4.5-4 Buildings, grounds, equipment, furnishings, materials, and supplies (5)

[45] Modified from 470 IAC 3-4.5-3 Water supply, plumbing, and sewage disposal and 470 IAC 3-4.7-114 Water supply and plumbing (f - i)

[46] Modified from 470 IAC 3-18-3 Fire and smoke detection systems

[47] Modified from 470 IAC 3-18-4 Fire extinguishers and 470 IAC 3-1.1-46 Fire prevention (m)

[48] Modified from 470 IAC 3-18-5 Exits (a) and 470 IAC 3-1.1-46 Fire prevention and 470 IAC 3-4.7-108 Door

[49] Modified from 470 IAC 3-1.1-46 Fire prevention

[50] Modified from 470 IAC 3-4.7-107 Hallways, stairways, and exits

10.3.4. Environmental fire hazards

10.3.4.a. Caregiver shall not permit trash or flammable and combustible materials, including but not limited to paper and rags, to accumulate upon the premises.

10.3.4.b. Portable, unvented oil-burning heating appliances shall not be used unless the heater complies with 675 IAC 22.

10.3.4.c. Electric or gas heaters and solid fuel-burning appliances shall not be located in such a manner that they block escape in case of fire arising from a malfunctioning stove, heater, or appliance.

10.3.4.d. When a fireplace serves as the primary source of heat, program shall provide glass doors, noncombustible hearth, grates, and proper fireplace tools for each fireplace in use while children are present. Child care providers shall ensure proper positioning of glass doors. If a fireplace is used at any time, it shall have a noncombustible hearth, screening, and grate. Program shall have the chimney flue inspected annually and cleaned if recommended. Program shall retain a written record of the inspections and cleanings for each fireplace used while children are present.

10.3.4.e. Caregiver shall properly dispose of ashes from the fireplace in a noncombustible, covered receptacle which shall then be placed on the ground and away from any building or combustibles.

10.3.4.f. Direct child care providers shall store flammable liquids in tightly sealed, marked containers appropriate to the type of liquid being stored. Direct child care providers shall store no more than five (5) gallons of flammable liquids at any one time in buildings used for child care and shall store all flammable liquids, lighters, and matches in an area inaccessible to children or in an approved fire cabinet.

10.3.4.g. Direct child care providers shall not store combustible material within five (5) feet of furnaces and water heaters.[51]

10.3.5. Knowledge of shut-off locations. The program shall identify the location and operation of the gas, electric, and water shut-offs and keep accessible the gas, electric, and water shut-offs in case of emergency.[52]

10.4. Firearms

10.4.1. Families are informed of the program's policy on firearms.

10.4.2. In residential settings, when children are present in the child care home, caregiver shall keep all ammunition and firearms in a locked area that is inaccessible to children at all times. Firearms are unloaded, equipped with protective devices, and stored separately from ammunition.[53]

10.4.3. In non-residential settings, use or possession of firearms is prohibited, unless required as a condition of employment. This information is posted on site.[54]

10.5. Lighting. Lighting is sufficient for staff to supervise children visually.

10.6. Flooring

10.6.1. Floors and steps shall be smooth and of washable, nonslippery material.

10.6.2. Flooring must be cleaned daily and maintained.

10.6.3. The program must firmly secure and keep all carpeting clean.

10.6.4. Small rugs may only be used in areas where children are not served, with the exception of nonslip rugs in bathrooms.

10.7. Outdoors/Playground

10.7.1. Playground and outdoor environment[55]

10.7.1.a. The program shall provide a protected outdoor play area that is safely enclosed by either a fence or natural boundaries for children in care.

10.7.1.b. The outdoor play area shall contain at least seventy-five (75) square feet for each child outdoors at any one time.

10.7.1.c. The outdoor play area must be free from hazardous elements.

---

[51] Modified from 470 IAC 3-1.1-46 Fire prevention

[52] Modified from 470 IAC 3-1.1-46 Fire prevention

[53] Modified from 470 IAC 3-1.1-48 Safety (e)

[54] Modified from 470 IAC 3-4.7-19 Posted items

[55] Modified from 470 IAC 3-4.7-69 Playground and outdoor environment and 470 IAC 3-4.7-68 Playground design, 470 IAC 3-4.7-66 Playground and outdoor safety

10.7.1.d. The outdoor play area must have appropriate safety surfaces to prevent injury from falls.

10.7.1.e. The outdoor play area shall be directly accessible from the inside of the program. If this is not possible and children must cross traffic areas, such as a street, alley, or parking lot, the following steps apply to crossing the area:

10.7.1.e.1. No child shall cross a traffic area unassisted.

10.7.1.e.2. Children shall wait at the edge of the traffic area.

10.7.1.e.3. The caregiver shall move to the center of the traffic area and assure that no autos are present or that all traffic is stopped.

10.7.1.e.4. The caregiver shall remain in the center of the traffic area until the last child has safely crossed the area.

10.7.1.e.5. When crossing public streets or other areas regularly traveled, caregivers shall display a flag, "Stop" sign, or other effective sign designed to halt traffic while children cross the area.

10.7.1.f. The outdoor play area and equipment shall be well drained and free from standing water.

10.7.2. Playground equipment. Play structures and equipment are in good condition and inspected for hazards daily.

10.8. Pest Management

10.8.1. All open windows, doors which are kept open for other than entering and leaving, ventilators, and other outside openings shall be protected against insects by securely fastened 16 mesh screening. Cracks shall be sealed and sealing shall be in place around pipes, plumbing, and ducts.[56]

10.8.2. The program shall keep all interior garbage, dirty diapering supplies, food products, and disposable meal service supplies in tight seamed, easily cleanable trash containers and cover them with tight-fitting lids pending removal.

10.8.2.a. Staff shall remove all garbage and refuse within the site daily to an outside tightly covered trash receptacle that will not permit the transmission of disease or provide harborage for insects, rodents, or other pests.

10.8.2.b. Staff shall clean trash containers when soiled.[57]

10.8.3. Children shall not be present during pest extermination procedures.[58]

10.9. Electrical Devices/Sources

10.9.1. Program uses tamper-resistant electrical outlets, safety covers, or safety plugs that prevent children from sticking fingers or objects into electrical outlets.[59]

10.9.2. Extension cords are not used, except for approved, grounded, surge protection strips that have been nationally tested. Such protection strips shall be plugged directly into an approved outlet.[60]

10.9.3. If fans or heaters are used, program shall provide models that are protected by safety devices which will not allow a child's fingers to come in contact with the blade or heating element.[61]

10.9.4. No electrical device or apparatus accessible to children shall be located so that it could be plugged into an electrical outlet while in contact with a water source, including, but not limited to, a sink, tub, shower, or swimming pool.[62]

10.10. Telephone

10.10.1. Telephone service must be provided on site.[63]

10.10.2. A wireless communication device must be available when transporting children and on field trips.

10.11. Toxic/ Hazardous Materials Management

10.11.1. A program will ensure that the following items are placed in areas that are inaccessible to the children in the provider's care:

10.11.1.a. Cleaning equipment, cleaning agents, aerosol cans, and any other item that states "keep out of the reach of children;"

10.11.1.b. Medications;

---

[56] Modified from 470 IAC 3-4.5-4 Buildings, grounds, equipment, furnishings, materials and supplies (4)

[57] Modified from 470 IAC 3-4.7-109 Garbage and refuse

[58] Modified from 470 IAC 3-4.7-118 Pest prevention (d)

[59] Modified from 470 IAC 3-4.7-101 Electrical safety

[60] Modified from 470 IAC 3-4.7-101 Electrical safety Sec. 101. (a)

[61] Modified from 470 IAC 3-1.1-48 Safety (b)

[62] Modified from 470 IAC 3-4.7-101 Electrical safety (d)

[63] Modified from 470 IAC 3-4.7-119 Office and staff areas

10.11.1.c. Tools, including, but not limited to: (1) power tools, (2) hand tools, (3) gardening tools, (4) sharp tools, (5) knives, and (6) flammable material.[64]

10.11.2. A program will ensure that the following items are placed in locked storage and inaccessible to children: poisons, chemicals, and any item that states "fatal if swallowed."[65]

10.11.3. Peeling paint, on any interior or exterior surface or on any equipment, that contains lead in excess of current ISDH standards shall be made inaccessible to children until laboratory analysis is made on the peeling material. The division shall approve all lead abatement procedures prior to the start of work.[66]

10.11.4. Any thermal hazards above one hundred twenty (120) degrees Fahrenheit, such as radiators, hot water pipes, steam pipes, and heaters, in the space occupied by children shall be out of reach of children or be separated from the space by partitions, screens, or other means, which are firmly attached and cannot be overturned.[67]

10.11.5. The program shall make inaccessible to children environmental hazards that present a risk for entrapment or burial, such as, but not limited to, the following:

10.11.5.a. Pits

10.11.5.b. Abandoned wells

10.11.5.c. Abandoned appliances[68]

10.12. Ventilation

10.12.1. The program shall ensure that the site is ventilated for normal occupancy.[69]

10.12.2. All restrooms shall be ventilated to the outside. If a screened window is not present, there shall be mechanical exhaust vents.[70]

10.12.3. Installation, testing, and maintenance of heating, ventilation, air conditioning, fire alarm, furnace rooms, and sprinkler systems shall comply with the rules of the FPBSC under 675 IAC.[71]

10.12.4. Appropriate room temperatures shall be maintained in all rooms

10.12.4.a. During winter months temperatures are no lower than 68 degrees Fahrenheit; and

10.12.4.b. During summer months, temperatures do not exceed 82 degrees Fahrenheit.

10.12.5. Heating units, including water pipes and baseboard heaters, hotter than one hundred ten (110) degrees Fahrenheit shall be inaccessible to children by barriers such as guards or other devices.[72]

10.12.6. The site shall not use the following heat sources: open grate gas heaters, (2) open fireplaces, (3) space heaters, (4) portable unventilated oil burning heaters, (5) portable electric heaters.[73]

11. Food Preparation and Service

11.1. Kitchen Practices

11.1.1. Location of Food Preparation Areas. Food preparation areas (kitchen space) should be separate from other areas of the program and not used as passage or throughways. The only exception should be allowed for programs in residential settings should it impact their ability to supervise children safely.

11.1.2. Equipment. The kitchen is equipped with:

11.1.2.a. a stove and oven or microwave;

11.1.2.b. a refrigerator; and

11.1.2.c. a sink with hot and cold running water, in operating condition sufficient to accommodate the food requirements of the number of children in care. All equipment should be maintained appropriately. Regarding the definition of equipment, Indiana can work toward an acceptable definition that is inclusive of refrigerators, ovens, ranges, freezers, and other necessary equipment to prepare and store food or sanitize before and after food preparation.

---

[64] Modified from 470 IAC 3-1.1-48 Safety and 470 IAC 3-4.7-100 Poisons, chemicals, and hazardous items (f) and(e)

[65] Modified from 470 IAC 3-4.7-100(a)

[66] Modified from 470 IAC 3-4.7-100 c (d)

[67] Modified from 470 IAC 3-4.7-100 (g)

[68] Modified from 470 IAC 3-4.7-100 (h)

[69] Modified from 470 IAC 3-1.1-45 General environment (e) and 470 IAC 3-4.7-106 (d)

[70] Modified from 470 IAC 3-4.5-4 Buildings, grounds, equipment, furnishings, materials and supplies and 470 IAC 3-4.7-113 Bathrooms

[71] Modified from 470 IAC 3-4.7-106 Heat, light, ventilation, and air conditioning (a)

[72] Modified from 470 IAC 3-4.7-106 Heat, light, ventilation, and air conditioning (i)

[73] Modified from 470 IAC 3-4.7-105 Prohibited heat sources

11.1.3. ***Sinks.*** Programs have two sinks: one exclusively for hand washing and the other for dishwashing.

11.1.4. ***Sanitation Practices***. All food preparation materials, serving items, and utensils are sanitized daily.

11.1.5. ***Prohibitions on Use***. Kitchen and food preparation area may not be used for children's activities or naps, a dining or recreational area for adults, or as an office.

11.1.6. ***Staff Hygiene.*** Staff shall wash hands before and after each child care duty such as individual feeding, bathing, diapering, or assisting a child with the toilet. When preparing food, staff shall thoroughly wash hands with soap and running water, before handling food. Staff shall wear clean, washable garments (e.g., apron) while handling food. Kitchen staff must have an effective hair restraint to keep hair back and covered. Staff experiencing any signs or symptoms of illness or open wounds shall not support the preparation of food.

11.2. Dishwashing[74]

11.2.1. Any multi-use utensils, tableware, or kitchenware shall be washed and sanitized between each use.

11.2.2. Dishwashing and sanitizing shall be conducted mechanically in a commercial dishwasher run on a sanitizing cycle or on a cycle that uses heat for full sanitization or manually in a three (3) compartment sink. One (1) of these may be a portable sink or container, deep enough to permit total immersion of the articles used by the facility.

11.2.3. The manual dishwashing procedure shall consist of thoroughly washing multi-use utensils and equipment in a detergent solution in the first compartment of the sink, and rinsing free of such solutions in the second compartment of the sink.

11.2.4. A sink used for dishwashing shall not be used for handwashing.

11.2.5. All eating and drinking utensils and, where required, the food-contact surfaces of all other equipment and utensils, shall be sanitized in the third compartment by one (1) of the following methods:

11.2.5.a. Immersion for at least one-half (1/2) minute in clean, hot water maintained at a temperature of at least 170° F.; or

11.2.5.b. Immersion for at least one (1) minute in clean water which is at a temperature of at least 75° F. and which contains an approved sanitizing agent at an effective concentration.

11.2.6. Cleaned and sanitized equipment and utensils shall always be air dried, never towel dried.

11.2.7. An alternative to dishwashing is the use of sturdy, all disposable, single-service articles and utensils.

11.2.8. Reuse of single-service articles and utensils is prohibited.

11.3. Food Delivery[75]

11.3.1. Direct child care providers must wash and sanitize all food preparation areas, serving areas, and utensils daily.

11.3.2. Each program using vendor service shall have a written contract that assures that the vendor's food service business, food handlers, and all premises are inspected and approved by local health authorities.

11.4. Feeding

11.4.1. There should be some language added into the regulatory code clarifying that programs can either choose to provide food or may choose to not provide food and instead require parents to provide a child's food for the day. This section of regulatory code should clarify what programs are still responsible for such as but not limited to:

11.4.1.a. Adhering to safe food handling practices;

11.4.1.b. Providing water throughout the day to children;

11.4.1.c. Having some snacks on-hand in case food from home is insufficient;

11.4.1.d. Safe food storage options (refrigerator and bottle warmers, etc.); and

11.4.1.e. General meal time requirements as applicable.

11.4.2. General Meal Guidelines:

11.4.2.a. On the initial serving of any particular meal, staff shall serve children full portions at the same time.

11.4.2.b. Food shall be covered during transport from kitchen.

11.4.2.c. Staff shall permit children to eat promptly when they sit down.

11.4.2.d. All food servers shall not touch ready-to-eat food with their bare hands.

11.4.2.e. Adults shall assist, supervise, converse, and sit with the children during all meals and snacks in age-relative groups, small enough in number to assure assistance and safety.

11.4.2.f. Children shall be allowed to converse freely during meal times and snacks.

[74] Modified from 470 IAC IAC 3-4.5-5 Food service sanitation

[75] Modified from 470 IAC 3-1.1-47 Sanitation (c) and 470 IAC 3-4.7-83 Vendor service

11.4.2.g. All food not prepared at the child care center or provided by an approved vendor must come in an unopened package from an approved food source.

11.4.2.h. Eating utensils, dishes, glasses, chairs, and tables shall be suitable for the age, size, and developmental level of the children.

11.4.3. Toddler Feeding

11.4.3.a. Caregivers shall wash their hands before feeding of toddlers.

11.4.3.b. Caregivers shall assist and assure that each toddler washes their hands before each meal.

11.4.3.c. Caregivers shall always use safety belts for securing the children when the children are in high chairs and feeding tables; when a child is able and seems ready to adjust to eating with others at a table, he or she may be placed at a child's table.

11.4.3.d. Caregivers shall remove children from their chair after eating.

11.4.3.e. Food must be cut up no larger than one-half (½) inch cubes.

11.4.4. Infant Food Preparation and Storage

11.4.4.a. Bottle Sterilizing

11.4.4.a.1. If bottles are to be washed and sterilized in the infant room, the center must provide a two (2) compartment sink for this purpose only.

11.4.4.a.2. The program shall post procedures for bottle sterilization where the sterilization takes place.

11.4.4.a.3. Hands shall be clean and care taken in handling technique to prevent contamination of clean bottles and nipples.

11.4.4.b. Formula

11.4.4.b.1. The parent or the program may provide formula.

11.4.4.b.2. All canned formula must be unopened, commercially prepared, and ready-to-feed strength.

11.4.4.b.3. There shall be a heating unit for warming bottles and food, accessible only to staff. Staff shall not heat formula in a microwave oven.

11.4.4.b.4. If a day's supply of bottles is prepared at one (1) time, each bottle shall be covered and labeled with the child's name, date, and time poured.

11.4.4.b.5. Staff shall refrigerate prepared bottles and use them within twenty-four (24) hours.

11.4.4.b.6. Staff shall cover and refrigerate portions of formula that remain in open original containers that are labeled with date and time opened and shall discard this formula after forty-eight (48) hours if unused.

11.4.4.b.7. Staff shall discard any formula remaining in a bottle after a feeding.

11.4.4.c. Storage and Handling of Human Breastmilk: Human milk storage and handling guidelines should be updated to incorporate the most recent Academy of Breastfeeding Medicine Protocol #8 from 2017 and also include the following provisions:

11.4.4.c.1. Programs shall use fresh, refrigerated breast milk within forty-eight (48) hours of the time expressed.

11.4.4.c.2. Staff shall not thaw or warm breast milk in a microwave oven.

11.4.4.c.3. Staff shall discard any breast milk remaining in a bottle after feeding.

11.4.4.c.4. Centers shall support mothers who are breastfeeding.

11.4.5. Infant Feeding Practices

11.4.5.a. The program shall acquire a feeding plan from the child's parent or guardian and post a copy of the child's feeding plan for use by food preparation personnel and the person responsible for feeding the child.

11.4.5.b. Caregivers shall adjust to infant's individual feeding schedules.

11.4.5.c. Caregivers shall hold infants while feeding them bottles.

11.4.6. Night Care Food Service

11.4.6.a. Staff shall serve an evening meal at a regular time each evening to all children who are in attendance and make the meal available to other children who may arrive later.

11.4.6.b. Staff shall serve a bedtime snack to each child.

11.4.6.c. Staff shall serve breakfast to all children who have been at the child care program throughout the night and are present at 6:30 a.m.

11.4.7. Picnics

11.4.7.a. In the event of a picnic with outdoor meal service, programs must keep cold foods under forty-one (41) degrees Fahrenheit; and

11.4.7.b. Provide equipment to maintain hot foods at one hundred forty (140) degrees Fahrenheit or above.

11.4.7.c. If cooking on an outdoor grill, programs shall:

11.4.7.c.1. Keep grills at least ten (10) feet away from the building;

11.4.7.c.2. Keep children at least fifteen (15) feet away from the grill;

11.4.7.c.3. Have an approved fire extinguisher readily available.

11.4.8.Special Meals/Allergies

11.4.8.a. The program shall post information regarding children's special diets for dietary staff in charge of preparing and serving the food.

11.4.8.b. Caregivers must plan and serve substitutions, written on a menu, for all children with dietary restrictions and, as applicable, in accordance with any written instruction of the child's physician.

11.4.8.c. A child requiring a special diet due to religious or personal beliefs shall have a written statement from the child's parent.

11.4.8.d. For special diets, the center may request that the parent supplement food served by the center.

11.4.8.e. If the parent provides food from home, the program must provide the parent information about "Safe Transportation of Food Responsibility," available from the division.

11.5. Nutrition

11.5.1. Licensure. Prior to initial licensure, the provider shall submit a written plan for nutrition and food service for approval to the division on forms provided for this purpose.

11.5.1.a. A written revised plan for nutrition and food service shall be submitted to the division for review and approval each time the food service plan undergoes any change as follows:

11.5.1.a.1. A change in the program.

11.5.1.a.2. The changing from vending to on-site food preparation and vice versa.

11.5.1.a.3. The program requests a change in licensure to include the care of children under two (2) years of age.

11.5.2. Nutrition Standards. Nutrition requirements shall be as follows: All programs shall provide meals and snacks that meet the dietary needs of each child as based on the current USDA Child and Adult Care Food Program (CACFP) 7 CFR 226.20, according to each child's age, the length of the child's daily program attendance, and meals served at home.

11.5.3. Drinking Water. A provider shall make available to each child in the provider's care clean, potable drinking water at all times.

11.5.4. Meal Times. (a) If the child's attendance at the child care program coincides with any meals and snacks that are provided by the center, the child shall be served those meals and snacks. (b) The center shall serve breakfast, a morning snack, lunch, and a mid-afternoon snack each day. (c) Staff shall serve a snack to school age children when they arrive at the child care program after school. (d) Staff are not required to serve meals to children that have already eaten that particular meal at another location.

11.5.5. Meal Components. A provider shall not offer foods that present a choking hazard to children under three (3) years of age, including, but not limited to, the following: (1) whole grapes, (2) hot dog rounds, (3) hard candy, (4) nuts, (5) seeds, (6) raw peas, (7) dried fruit, (8) pretzel nuggets, (9) chips, (10) popcorn, (11) marshmallows, (12) spoonfuls of peanut butter, (13) chunks of meat larger than children can swallow whole.

11.5.6. Special Diets

11.5.6.a. The provider shall post information regarding children's special diets for dietary staff in charge of preparing and serving the food.

11.5.6.b. The provider must plan and serve substitutions, written on a menu, for all children with dietary restrictions.

11.5.6.c. For children requiring a special diet due to medical reasons or allergic reactions, the provider shall provide meals and snacks in accordance with the child's needs and the written instructions of the child's physician.

11.5.6.d. A child requiring a special diet due to religious or personal beliefs shall have a written statement from the child's parent.

11.5.6.e. For special diets, the provider may request that the parent supplement food served by the program.

11.5.6.f. All food items must be protected from damage and potential contamination.

12. Health Promotion and Protection

12.1. Diapering and Toilet Training[76]

12.1.1. Diapering

12.1.1.a. The program shall provide an area for diaper changing with an easily cleaned and sanitized surface on which the infant or toddler may be placed. The diaper changing surface must have waterproof material between the child and the surface of the changing area. This material shall be changed after each use. The diaper changing area shall be sanitized daily and when soiled.

12.1.1.b. Staff must keep a hand on the child at all times while diapering.

12.1.1.c. Programs shall supply a tightly covered, easily sanitized container for wet or soiled diapers.

12.1.1.d. If a disposable liner or gloves are used, they are placed in a plastic-lined, hands-free, covered can. Any clothing that was soiled is placed in a plastic bag that is securely tied.

12.1.1.e. Direct child care providers changing diapers shall wash their hands with soap and running water before and after each diaper change. Children's hands must be washed after the diaper change.

12.1.1.f. Staff document the diaper change, diaper contents, and/or any problems.

12.1.2. Toilet Training.[77]

When a chair designed specifically for toilet training is used, direct child care provider shall empty it after each use and sanitize it at least daily.

12.2. Health Policies and Practices

12.2.1. Health Policy. Prior to initial licensure, the child care program shall submit a written, dated health program policy for review and approval to the division on forms provided for that purpose.[78]

12.2.2. Child Health Records.[79]

Within thirty (30) days of a child's enrollment, the child's health record shall contain the following:

12.2.2.a. Physical examination verification form with physician's or nurse practitioner's signature dated no earlier than twelve (12) months prior to enrollment date, which includes whether the child has allergies or any chronic health conditions and modifications of plans of care required.

12.2.2.b. Current and complete record of immunization history showing month, day, and year of each immunization.

12.2.2.c. Parent-provided health history (at admission, with updates as needed).

12.2.2.d. Medication records.

12.2.2.e. Consents signed by the parent: (1) emergency medical authorization to provide transportation and obtain medical treatment for children when the parent cannot be contacted. This authorization shall also be in the emergency information file. Nothing in this subsection precludes the child care home from using emergency measures to treat such a child by first aid techniques or to exclude the child where control of a contagious disease may be necessary.

12.2.2.f. Infant and toddler charts and records should be maintained by the program on a daily record chart in each infant and toddler room. This chart shall provide space to record information about each child as follows: (1) food and fluid offered and taken, (2) time of diaper changes, (3) unusual mood of the child, (4) unusual health conditions, such as: (A) nose bleeds, (B) skin rash, (C) elevated temperature, (D) signs of constipation or diarrhea, (E) injuries, and (F) special health needs. The center shall keep charts on file for at least one (1) month.

[76] Modified from 470 IAC 3-1.2-6

[77] Modified from 470 IAC 3-1.2-6 Diaper changing and toilet training

[78] Modified from 470 IAC 3-4.7-2 Licensing requirements and 470 IAC 3-4.7-84 Health program

[79] Modified from 470 IAC 3-4.7-38 Children's health records, 470 IAC 3-4.7-37 Signed consent forms, and 470 IAC 3-4.7-122 Infant/toddler charts and records

12.2.3. Immunizations.[80]

Maintain and annually update documentation provided by the physician of each child who is cared for in a child care program, which indicates whether the child has received complete age-appropriate immunizations, including: (1) conjugated pneumococcal vaccine, and (2) varicella vaccine or a demonstrated immunity to varicella. The Indiana Department of Health shall determine for each age level the immunizations that constitute complete age-appropriate immunizations.

12.2.3.a. The provider's records must include the following: (1) a current list of all children cared for at the facility, (2) the child's date of birth, (3) the month, day, and year of each immunization received or: (A) a written statement from the child's physician, updated annually, stating a medical reason the child should not be immunized; or (B) written documentation, updated annually, that the parent objects to immunizations for religious reasons. The documentation required by this section shall be made available to the verifying agency.

12.2.3.b. A program meets the requirement of subsection (a) if: (1) a child's parent: (A) objects to immunizations for religious reasons; and (B) provides documentation of the parent's objection; (2) the child's physician provides documentation of a medical reason the child should not be immunized; or (3) the child's physician provides documentation that the child is currently in the process of receiving complete age-appropriate immunizations; and the program maintains and annually updates the documentation provided by the parent or physician under this subsection.

12.2.4. Medication Administration and Storage[81]

12.2.4.a. Child care providers shall give or apply medication only with prior written permission from a parent or legal guardian, which is kept on file.

12.2.4.b. Child care providers shall give or apply medication only with clear, written instructions as to the dosage, time, and reason medication is to be given. Medication must be labeled with the child's name, physician's name, and pharmacy. Over-the-counter medication must also be labeled with the child's name. The caregiver shall keep a record of the date, time, and dosage of medication given.

12.2.4.c. Medication is stored as indicated on the manufacturer's instructions and shall be administered as directed on the label of the medication or as specified by the consulting physician.

12.2.5. First Aid and Emergency Contacts[82]

12.2.5.a. The child care program must keep a Red Cross First Aid Manual or its equivalent accessible to staff.

12.2.5.b. The caregiver must maintain a first aid kit (as recommended by the American Red Cross First Aid Manual or its equivalent), including, but not limited to, syrup of ipecac with current date.

12.2.5.c. Transportable first aid kits are 1) available in vehicles used by the program to transport children, and 2) available and taken when leaving the program on walks.

12.2.5.d. First aid kits and supplies are restocked after use.

12.2.5.e. The following universal precautions supplies shall be available to all staff: (1) disposable medical gloves, (2) plastic bags, (3) one (1) part chlorine to nine (9) parts water or other EPA-approved tuberculocidal solution for cleaning blood or other potentially infectious materials as defined by OSHA, and (4) cardiopulmonary resuscitation barrier masks.

12.2.5.f. The caregiver shall keep the phone numbers of the ambulance, police, fire department, poison control center, and nearest hospital by the telephone.

12.2.6. Prohibition of smoking, use of alcohol, tobacco, and other substances.[83]

A provider shall have a written policy prohibiting the use of the following in the facility where the provider operates a child care program when child care is being provided: (1) tobacco, (2) alcohol, (3) a potentially toxic substance that can be used in a manner other than the substance's intended purpose, and (4) an illegal substance or the possession of an illegal substance.

---

[80] Modified from IC 12-17.2-5-18.1 Immunizations IC 12-17.2-4-18.1 Immunizations IC 12-17.2-3.5-11.1 470 IAC 3-18-17 470 IAC 3-4.7-86 Child health requirements (d)

[81] Modified from 470 IAC 3-1.1-44 Health(f), 470 IAC 3-4.7-40, and 470 IAC 3-4.7-88

[82] Modified from 470 IAC 3-1.1-44 Health and 470 IAC 3-4.7-90 Universal precautions supplies

[83] Modified from 470 IAC 3-18-18 Tobacco and substance policy

12.3. Pets/Animals[84]

If a program has pets or animals, they follow the following rules:

12.3.1. Pets kept by the center shall be free from diseases with potential for transmission to humans.

12.3.2. All animals must have appropriate and regular veterinary care, and proof of rabies vaccination for dogs and cats, according to local or state requirements.

12.3.3. There shall be no ferrets, turtles, reptiles, psittacine birds (birds of the parrot family), or any wild or dangerous animals permitted in a child care program.

12.3.4. Animals shall not roam freely and shall be housed in a manner that prevents injury to either the children or the animal.

12.3.5. Animal cages shall permit proper sanitation and have removable bottoms.

12.3.6. Children's contact with animals is supervised, including supervision to prevent children from putting their hands or objects (e.g., pacifiers) in their mouth while around animals.

12.3.7. Areas where animals have been are cleaned and disinfected.

12.3.8. Staff and children shall wash their hands after handling, feeding, or cleaning pets or the pet's environment.

12.3.9. Parents of children who have allergies, asthma, or other illnesses are consulted to determine special considerations.

12.3.10. Cleaning tanks, feeders, water containers, and other equipment are not kept in sinks or areas where food is prepared, served, or eaten.

12.4. Prevention and Control of Infectious Diseases

12.4.1. Child care providers shall see that children's hands are washed at a sink with soap and warm running water for at least 20 seconds before meals and snacks and after toilet use.[85] Hand sanitizer use must be supervised if a child is under six years old.

12.4.2. There is a routine schedule of cleaning, sanitizing, and disinfecting materials. Children should not be near products used in these activities.

12.4.3. If a child is ill, the program must (1) care for the child in an area separate from the other children; (2) notify the child's parent or legal guardian; and (3) monitor the child until the parent or legal guardian arrives. All surfaces and items with which a sick child has come in contact shall be cleaned and sanitized after each use. Individual belongings shall be kept separate.[86]

12.4.4. (a) The program shall establish written health policies and precautions on controlling the spread of communicable diseases. (b) Whenever exposure to disease has occurred in the child care program, control measures shall be implemented as follows through: (1) the disinfection of toilet facilities, furnishings, toys, or other articles that may have been used by a person with a communicable disease; (2) the disposal of bodily discharge containing infectious material in a manner that would protect handlers from contact with the material. (c) When any person working, volunteering, or attending the child care program is known to have a communicable disease, they shall be excluded from attendance at the child care program for such time as is prescribed by the person's physician or the local health officer. (d) The program shall ascertain when the person is well enough to return to work. (e) The program shall follow the Child Care Communicable Disease Chart, available from the division, for appropriate management of suspected illness. (f) When more than one (1) child in the child care program has been diagnosed with a communicable disease, the center shall take the following action: (1) the program shall immediately notify all parents of the children and all staff members that have been exposed by posting a notice in a conspicuous place in the child care program or by giving a personal note to each parent and staff member; and (2) the program shall call one or more of the following: (A) the local health department for consultation, (B) the division's child care health section, or (C) the child care program's health consultant.[87]

12.5. Safe Sleep Practices/Rest

12.5.1. A separate bed, cot, mat, or sleeping bag shall be provided for each child. The program may use washable cots, sleeping bags, or mats for toddlers over twenty-four (24) months of age.[88]

---

[84] Modified from 470 IAC 3-4.7-65 Pets

[85] Modified from 470 IAC 3-1.1-44 Health (c) and 470 IAC 3-4.7-1 (38)

[86] Modified from 470 IAC 3-1.1-44 Health (d) and 470 IAC 3-4.5-6 General sanitation (c) Ill Children.

[87] Modified from 470 IAC 3-4.7-89 Communicable disease and 470 IAC 3-4.7-14 Reporting communicable disease

[88] Modified from 470 IAC 3-1.1-43 Sleep and rest

12.5.2. A period for sleep, rest, or quiet time shall be provided during the day for children under five (5) years of age consistent with the needs of the child and in accordance with the wishes of the parent.[89]

12.5.3. Cribs, portacribs, and cots must meet U.S. Consumer Product Safety Commission standards and not have been recalled. They must have firm-fitting mattresses or pads made of waterproof materials.

12.5.4. Cribs and cots must be sanitized at least daily.[90]

12.5.5. Cribs or cots are sanitized and bedding is changed between each child's use if two (2) or more part-time children share the same crib or cot.[91]

12.5.6. Staff have sufficient room between cribs, cots, or other sleep furniture/equipment to move between them.

12.5.7. All bedding shall be changed immediately when wet or soiled, and otherwise once each day.[92]

12.5.8. Staff working with infants and toddlers follow safe sleep practices defined by the American Academy of Pediatrics (AAP), including:

12.5.8.a. Staff place infants on their backs or sides in their cribs for sleeping.[93]

12.5.8.b. Infants have their own sleep space with no other people.

12.5.8.c. Infants sleep in a crib, bassinet or portable play yard with a firm, flat mattress and a fitted sheet.

12.5.8.d. Loose blankets, pillows, stuffed toys, bumpers and other soft items are kept out of the sleep space.

13. Safety

13.1. Emergency Preparedness

13.1.1. Evacuation procedure.[94] A program shall make plans for the protection of children in the event of a disaster. The program shall post written disaster, evacuation, and shelter procedures for an internal and an external disaster that explains the emergency plans and evacuation procedures the program would adhere to in the event of an emergency including:

13.1.1.a. Evacuation emergencies (e.g., gas leak or fire)

13.1.1.b. Shelter-in-place emergencies (e.g., tornado)

13.1.1.c. Lockdown emergencies (e.g., violent or hostile intruder)

13.1.1.d. Lockout emergencies (e.g., dangerous person reported in the area) and children, staff, or volunteers need to be brought back inside and the building secured.

13.2. Emergency Drills[95]

13.2.1. Staff shall conduct fire drills in accordance with the rules of the FPBSC under 675 IAC.

13.2.2. Staff shall conduct evacuation drills for natural disasters in areas where they occur as follows: (1) tornadoes, on a monthly basis, (2) floods, every six (6) months, (3) earthquake, every six (6) months.

13.2.3. The provider shall maintain documentation of all fire drills conducted during the immediately preceding twelve (12) month period, including the following: (1) the date and time of the fire drill, (2) the name of the individual who conducted the fire drill, (3) the weather conditions at the time of the fire drill, and (4) the amount of time required to fully evacuate the facility.

13.2.4. Emergency plans.[96]The provider shall have written plans posted in the facility where the provider operates a child care program notifying the parent of the following: (1) illness, serious injury, or death of the provider, (2) how care will be provided in an emergency, (3) the identity of the person or persons responsible for notifying parents, and (4) the identity of the person or persons responsible for providing care should the provider be unable to provide care due to an emergency.

13.2.4.a. Accommodations. A written plan must be in place for how the program could accommodate children who are multilingual learners and children with disabilities, special health care needs, or developmental delays.

---

[89] Modified from 470 IAC 3-1.1-43 Sleep and rest

[90] Modified from 470 IAC 3-4.7-141 Infant/toddler sleeping (m)

[91] Modified from 470 IAC 3-4.7-141 Infant/toddler sleeping (n)

[92] Modified from 470 IAC 3-4.7-141 Infant/toddler sleeping (o)

[93] Modified from 470 IAC 3-4.7-141 Infant/toddler sleeping (b)

[94] Modified from 470 IAC 3-4.7-92 Evacuation procedures

[95] Modified from IAC 470 IAC 3-4.7-103 Emergency drills

[96] Modified from IAC 470 IAC 3-18-12 Emergency plans

13.3. Equipment Maintenance and Safety[97]

13.3.1. Educational equipment and materials

13.3.1.a. The provider shall clean and sanitize equipment and materials a minimum of once per week.

13.3.1.b. All play equipment and materials shall be constructed and installed in a manner that is safe for use by children.

13.3.1.c. All indoor gross motor equipment shall meet the Consumer Product Safety Commission's guidelines for safety surfaces.

13.3.1.d. Projectile toys are prohibited.

13.3.1.e. Equipment and play materials shall be durable and free from characteristics that may be hazardous or injurious. Hazardous or injurious characteristics include, but are not limited to: (1) sharp edges; (2) rough edges; (3) toxic paint; and (4) objects small enough for children to swallow.

13.3.1.f. Tricycles used by children shall be spokeless, steerable, of age-appropriate size, and have a low center of gravity.

13.3.1.g. When riding bicycles, children shall wear safety helmets that meet national safety standards.

13.3.2. Infant/toddler equipment

13.3.2.a. The center shall provide indoor and outdoor play materials and equipment for caregivers to use with infants and toddlers to stimulate learning, growth, health, and development.

13.3.2.b. Diaper bags and car seats from home shall not be allowed in the infant and toddler rooms.

13.3.2.c. All articles that are used by infants or toddlers shall be sanitizable and sanitized daily and whenever soiled.

13.3.2.d. Caregivers shall not attach pacifiers, if used, near or around the child's neck.

13.4. Water Safety

13.4.1. Swimming, body of water, or wading pool[98] (applies if pool, lake is on the premises of the program OR if program takes a field trip).

13.4.1.a. Child/staff ratios shall be twice the number required in this rule.

13.4.1.b. The program may count employed lifeguards in child-staff ratios.

13.4.1.c. A person having a valid Red Cross advanced life saving certificate shall be on duty at all times when a swimming pool or lake is in use.

13.4.1.d. The caregiver shall be physically present at the swimming or wading pool or lake to supervise and provide "touch supervision" when the children in care are swimming or wading.

13.4.1.e. At least one (1) direct child care provider shall be available to supervise any children not swimming or wading in addition to staff requirements in section 36.5 of this rule.

13.4.1.f. Child care providers shall empty portable wading pools immediately after use.

13.4.1.g. All inground or nonportable aboveground swimming pools accessible to children shall be in compliance with local zoning ordinances and surrounded by a fence secured with a locked gate to prevent children from entering the area unsupervised.

13.4.1.h. Written parental permission shall be obtained and kept on file prior to a child participating in a swimming activity.

13.4.1.i. Each swimming area must have a minimum of two (2) flotation devices.

13.4.2. Pool and lake equipment, maintenance, and storage (only applies if pool or lake is privately owned)

13.4.2.a. All private lakes must have their water tested and approved for swimming.

13.4.2.b. In addition, permanently constructed swimming or wading pools located on the premises of the child care program shall meet the following:

13.4.2.b.1. The program must construct the pool in accordance with FPBSC rules under 675 IAC 20 and maintain it in accordance with ISDH rules under 410 IAC 6-2.1.

13.4.2.b.2. All inground or nonportable aboveground swimming pools accessible to children shall be in compliance with local zoning ordinances and surrounded by a fence secured with a locked gate to prevent children from entering the area unsupervised.

[97] Modified from 470 IAC 3-4.7-131 Infant/toddler equipment; general and 470 IAC 3-4.7-153 Night care program and equipment

[98] Modified from language from 470 IAC 3-1.1-39 Swimming and 470 IAC 3-4.7-70 Water play areas

13.4.2.b.3. Inground or nonportable aboveground swimming pools must be covered or emptied in the off season.

13.4.3. Water tables[99]

13.4.3.a. Children should wash hands before and after playing in a water table.

13.4.3.b. Staff shall empty the water table daily and clean it with an approved sanitizing solution before being air-dried.

13.4.4. Prohibitions. Staff shall not permit children to be in hot tubs, spas, or saunas.

13.5. Reporting Child Abuse, Injury. *This section of IAC is not modeled because it interacts with other sections of Indiana statute. Instead, suggested components of the section of IAC are discussed.* Components of IAC should be the following:

13.5.1. Address investigating allegations of abuse or neglect within any child care setting;

13.5.2. The responsibility of a caregiver to report child abuse and neglect;

13.5.3. Adherence/compliance with federal requirements;

13.5.4. Language could be modeled off the current Indiana Code that governs programs receiving vouchers (IC 12-17.2-3-8-5).

14. Transportation

14.1. Parental Consent and Program Responsibility. Program shall obtain written or digital parental permission before taking a child away from the child care site for field trips or any other activities.[100]

14.1.1. If the program transports children to and from the child care site, responsibility is assumed from time picked up to time dropped off.[101]

14.2. Driver Qualifications. The driver:

14.2.1. Is at least 18 years of age and holds a proper license to operate the vehicle;

14.2.2. Has not used alcohol within twelve (12) hours prior to transporting children;

14.2.3. Does not use illegal drugs;

14.2.4. Ensures that any prescription drugs will not impair their ability to drive;

14.2.5. Does not have any medical conditions that would affect their ability to safely operate the vehicle; and

14.2.6. Can be required to take a drug test if illegal drug use or alcohol intake is suspected by the operational point of contact or other staff in program leadership roles.[102]

14.3. Passenger Restraint System. Children shall be transported in safety restraint equipment that is in compliance with state laws and IC 9-19-11.[103] When transporting a child in a wheelchair, vehicles shall accommodate the placement of wheelchairs with tie downs affixed according to the manufacturer's instructions.[104]

14.4. Protocols to Ensure No Children Unattended in Cars. Protocols include:

14.4.1. Locking the vehicle when not in use, with a check that no children are in the car before locking;

14.4.2. Taking head counts of children before and after transport; and

14.4.3. Never leaving a child unattended in a vehicle.

14.5. Emergency Preparedness. Staff have emergency medical authorization for all children and emergency contact numbers for all occupants.

14.6. Liability Insurance. Carry liability insurance to cover all passengers riding in the vehicle.[105]

14.7. Vehicles. The vehicle is:

14.7.1. Properly licensed with state of Indiana laws;

14.7.2. Maintained in good condition, including working locks and an interior that is well-ventilated;

14.7.3. Visually inspected from staff to ensure the interior is clean and free of obstructions on the floors, seats, and windows.

14.8. Safety precautions during transportation.

14.8.1. Load and unload children from the curbside of the vehicle.[106]

---

[99] Modified from 470 IAC 3-4.7-70 Water play areas

[100] Modified from 470 IAC 3-1.1-40 Transportation and activities away from the child care home (a)

[101] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicle

[102] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicle

[103] Modified from 470 IAC 3-1.1-40 Children's medication records (b) and 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicle (4)(C)

[104] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (7)

[105] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (2) (D)

[106] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (3) (B)

14.8.2. Children are not seated in the front seat of vehicle.[107]
14.8.3. Turn the vehicle off when loading or unloading children. (This does not apply to regulation school buses.)[108]
14.8.4. Passenger count does not exceed the manufacturer's rated passenger capacity.[109]
14.8.5. Doors are locked during vehicle operation.
14.8.6. Maintain child-staff ratios when transporting children, except when transporting more than twelve (12) children on a school bus or Head Start bus to and from school or home, and have at least one (1) qualified caregiver not including the driver supervise the children.[110]

[107] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (2)(F)
[108] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (4)(B)
[109] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (2)(I).
[110] Modified from 470 IAC 3-4.7-72 Transportation in child care center owned or leased vehicles (2)(B)

Appendix A – Stakeholder Engagement

The following entities and individuals participated in virtual interviews, focus groups, or regional stakeholder meetings held by ELAC as part of the stakeholder engagement process. These included licensing consultants, child care providers, and representatives from the out-of-school time community.

Indiana Licensed Child Care Home Advisory Committee Focus Group

- Marci Graves
- Noel Hanson
- Rebecca Kenworthy
- Jennifer Kuhnle
- Stephanie McKinstry
- Joey Scherschel
- Cindy Vaughn

Indiana Licensed Child Care Center Advisory Board Focus Group

- Christi Dolezal
- Mike Garatoni
- Noel Hanson
- Jane Wiechel

Indiana Child Care Licensing Consultants

- Jennifer Beam
- Carolyn DeGroote
- Amanda Foss
- Debra Iams
- Diane Kendall
- Brianna Lemacks
- Holly Marvel
- Erin McCollum
- Carrie Moore
- Joy Shell

Interviews

- Mike Garatoni, President, Growing Kids Learning Centers
- Lakshmi Hasanadka, Chief Executive Officer, Indiana Afterschool Network
- Louise Stoney, Facilitator, Indiana Licensing Workgroup

Regional Stakeholder Meetings

Central

- Justin Armstrong, AYS
- Shelley Ashley, Goodwill of Central and Southern Indiana
- Holly Curtsinger, Indiana State University Early Childhood Education Center
- Angela Johnson, Lewis Cass Early Learning
- Julie Kilger, United Way of Central IN
- Dionne Miller, Room to Bloom Learning Academy
- Brent Wake, Indiana Afterschool Network
- Lisa Walter, Montgomery County Community Foundation/Montgomery County Early Childhood Coalition

Northeast

- Jenna Anderson, Thrive by 5, Lagrange and Noble
- Madeleine Baker, Early Childhood Advocate
- Courtney Bonbrake, Early Childhood of Huntington County
- Kimberly Brooks, Fort Wayne Community Schools
- Cassie Eberly, INAEYC
- Julie Garber, Community Foundation of Wabash County
- Jennifer Kuhnle, Jennifer's Kiddie College
- Missy Modesitt, Muncie By 5
- Sherry Searles, LaunchPad
- Allie Sutherland, Northeast Indiana Early Childhood Coalition
- Amber Taggart, Early Childhood Alliance

Northwest

- Peggy Buffington, School City of Hobart
- Mark Chamberlain, CAPTRUST/Duneland Y
- Mary Jane Eisenhauer, First Things First Porter County
- Mike Garatoni, Growing Kids Learning Centers
- Sara Gutierrez, School City of Hobart Northwest
- Megan Inskeep, Appleseed
- Stephanie Johnson, Appleseed
- Lisa Johnson, Lisa's Safe Haven Childcare
- Tammy Lindblom, Right Steps

Southeast

- Jill (Hammer) Harden, Children Inc.
- Ryan Lauber, South Ripley Elementary School
- Rob Moorhead, ELAC Member, South Ripley Schools
- Christine Waters, Community Education Commission, Columbus
- Phebe West, Learn by Heart

Southwest

- Tara Bishop, Perry Central Schools
- Nash Dunn, KCARC Civitan Children's Center
- Erin Emerson, Perry Childcare/Perry County Development Corp
- Glenn Etionne, Perry Central Schools
- Kim Grizzel, Boys & Girls Clubs of Harrison-Crawford Counties
- Derek Hopper, KCARC Civitan Children's Center
- Jennifer Mitchell, Perry Central Schools
- Jennifer Myers, Monroe Smart Start/Community Foundation of Bloomington and Monroe County
- Martha Thomas, Lincoln Hills Development Corporation Head Start
- Krista Wedding, St. Vincent Early Learning Center