National Resource Center for Health and Safety in Child Care and Early Education

Frequently Asked Questions

Caring for our Children - 3rd Edition (CFOC3, 2011)

Date	Topic & Location	Question	Answer
10/13/2011	**General**	Do the *CFOC3* standards address the updated Americans with Disabilities Act (ADA) guidelines?	*CFOC3* recommends that the ADA guidelines be adhered to in related standards. *CFOC3* does not specifically address updated or new ADA guidelines.
CHAPTER 1: Staffing			
10/13/2011	***Chapter 1*** Staffing 1.1.1 Child:Staff Ratio and Group Size pp.3-7	Is *CFOC3* recommending that programs do not need to meet staffing ratios during nap time for children older than 31 months?	Yes, for large family child care homes and centers. However, maximum group size must be maintained.
10/13/2011	***Chapter 1*** Staffing 1.4.3 First Aid and CPR Training pp.24-26	If a staff member is certified in pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) from the American Heart Association (AHA) or Red Cross (which follows the AHA guidelines), is it reasonable to assume that rescue breathing skills were included in the CPR course? If not, it sounds like teaching staff would need to take healthcare provider level training in order to receive training in rescue breathing.	Yes. The key is that providers be required to take **pediatric** first aid and CPR.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 1*** Staffing 1.6 Consultants pp.33-39	The National Association for the Education of Young Children (NAEYC) criterion 5.A.02 and its “guidance” state that the health consultant is “either a licensed pediatric health professional or a health professional with specific training in health consultation for early childhood programs.” “Licensed pediatric health professionals include (but are not limited to) pediatricians, family practice physicians, pediatric nurses, or pediatric nurse practitioners. Child care health consultation is a growing specialty for which training is available.” Do the individuals described in the NAEYC criteria meet the *CFOC3* standard regarding the qualifications for a health consultant?	Yes.
10/13/2011	***Chapter 1*** Staffing 1.6 Consultants pp.33-39	How frequently should the health consultant visit the program?	The child care health consultant should visit each facility as needed to review and give advice on the facility’s health component. State child care regulations display a wide range of frequency and recommendations in states that require CCHC visits, from as frequently as once a week to twice a year, depending on the age that a program serves (see page 36).
10/13/2011	***Chapter 1*** Staffing 1.6 Consultants pp.33-39	There seems to be a stronger focus in the *CFOC3* standards on mental health consultants. Could a general health consultant fulfill this role or would the individual need specific training in mental health issues?	The philosophy behind the three standards (general health, early childhood mental health, and early childhood education consultants) is that there is a continuum of care. The CCHC would often be first to determine that a mental health consultant should be involved for more intense consultation; likewise a mental health consultant may refer general issues back to the CCHC.

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Date	Topic & Location	Question	Answer
CHAPTER 2: Program Activities for Healthy Development			
10/13/2011	***Chapter 2*** Program Activities Standard 2.2.0.2: Limiting Infant/Toddler Time in Crib, High Chair, Care Seat, Etc. p.66	Please provide more contexts surrounding the research that informed the recommendation that "children should not be left to sleep in equipment, such as car seats, swings, or infants seats that do not meet the ASTM International (ASTM) product safety standards for sleep equipment." Is part of the intent regarding this standard to educate parents about safe infant sleep practices or is it actually dangerous for infants to sleep sitting up, or both?	Both. Extended periods of time in the crib, high chair, car seat, or other confined space limits infants' physical growth (gross motor development) and also affects their social interactions. Injuries and Sudden Infant Death Syndrome (SIDS) have occurred when children have been left to sleep in car seats or infants seats. Please see the Standard's rationale and references for information on related injuries and SIDS.
CHAPTER 3: Health Promotion and Protection			
10/13/2011	***Chapter 3*** Health Promotion 3.1.4 Safe Sleep pp.96-101	Does the American Academy of Pediatrics (AAP) recommend pacifier use for infants who have already established breastfeeding as a means to help prevent Sudden Infant Death Syndrome (SIDS) or is the research on this topic still emerging?	Both.
10/13/2011	***Chapter 3*** Health Promotion 3.1.4 Safe Sleep pp.96-101	*CFOC3* states that no monitors should be used. Does this mean no heart/ breathing monitors should be used or no mirrors/videos/sound monitors?	*CFOC3* states that no "heart/breathing" monitors should be used unless ordered by the child's primary care provider (see page 96).
10/13/2011	***Chapter 3*** Health Promotion 3.1.4 Safe Sleep pp.96-101	What research supports the recommendation that infants sleep in the same room as the caregiver and how does this relate to best practice issues regarding the "separation" of infant active play areas from infant sleep areas? There seems to be considerable research in the home environment in regards to infants sleeping in the same room as the parent(s) at home to decrease the incidence of SIDS. However, there doesn't seem to be research regarding the use of separate infant nap rooms in child care environments. What other research studies support this practice or is the recommendation erring on the side of caution due to potential program liability issues?	Currently, there are no data to support the recommendation that babies sleep in the same room as a caregiver/teacher in an early care and education setting since caregivers/ teachers do not typically sleep in these settings. This practice, as discussed in Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction (p. 96), is a best practice to ensure that there is appropriate supervision of sleeping infants.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion 3.1.4 Safe Sleep pp.96-101	Because SIDS has no outward signs of distress by the infant, what should teachers be looking for when supervising sleeping infants other than overheating?	Caregivers/teachers should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets). Also, caregivers/teachers should ensure that the infant's head remains uncovered and readjust clothing as needed (see page 96).
10/13/2011	***Chapter 3*** Health Promotion 3.1.5 Oral Health pp. 101-104	Is it correct that there is no research to support the practice of wiping an infant's gums after feeding to prevent dental caries? Is this practice effective for infants who have teeth?	There is currently no **strong** research that shows any benefit to wiping the gums of a baby who has no teeth. Yes.
10/13/2011	***Chapter 3*** Health Promotion Standard 3.2.1.1: Type of Diapers Worn p.104	Does this standard allow for use of the newer cloth diapers (with either a removable or connected absorbent inner liner and waterproof Velcro closure cover) when a medical reason for their use has not been documented?	Yes, but only if the cloth diaper and cover are removed simultaneously as one unit and not removed as two separate pieces (see page 105). Please review the Comments section of this Standard for more information.
10/13/2011	***Chapter 3*** Health Promotion 3.2.1 Diapering and Changing Soiled Clothing pp.104-110	Is it ok to allow older children to be changed standing on the floor (i.e. in the bathroom)?	Yes.
10/13/2011	***Chapter 3*** Health Promotion 3.2.1 Diapering and Changing Soiled Clothing pp.104-110	Is there clear research that cloth diapers are not effective in preventing environmental contamination or is there just limited research on the topic?	There is limited research on this topic.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion Standard 3.2.1.4: Diaper Changing Procedure p.106	Is the recommendation for an Environmental Protection Agency (EPA) -registered disinfectant different from the previous cleaning and sanitizing definitions? What's the difference between a disinfectant and sanitizing agent?	For some surfaces it is important to disinfect to be healthy and safe (this is the deepest "clean"). For some surfaces sanitizing is enough to be healthy and safe, and for some surfaces cleaning is adequate. Remember that before some surfaces are disinfected or sanitized, the visible "dirt" must first be cleaned off. Please see Appendix J, Selecting an Appropriate Sanitizer or Disinfectant (p.440) for more information.
11/22/2011	***Chapter 3*** Health Promotion Standard 3.2.1.4: Diaper Changing Procedure p.106	What is the rationale for requiring hand washing before diaper changing?	The diaper changing process may require many interactions with the child before the process, for example evaluating whether the diaper contains stool. Because of the potential for contamination of hands during this process, hand hygiene should be performed before collection of diaper supplies and further handling of the child to avoid contaminating the remaining diaper supplies. However, activities in child care do not occur in isolation. If hand hygiene has been done for another reason prior to a diaper changing event, the process does not have to be repeated if no contamination of hands has occurred.

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Date	Topic & Location	Question	Answer
Updated 11/30/2011	***Chapter 3*** Health Promotion Standard 3.2.1.4: Diaper Changing Procedure p.106	What is the rationale for using wet paper towels or cloths for the girls' labia? I understand if the child had a diaper rash or allergy, wet paper towels or cloths would be recommended; however, if the child's skin is intact, why couldn't regular diaper wipes be used?	A wet paper towel or cloth should be used for the genitals. Baby wipes are safe to use on skin, but they could be irritating to the mucus membranes inside the labial folds. "Because the prepubertal child is susceptible to both nonspecific and specific vaginal infections and a variety of vulvar skin abnormalities" which can easily be traumatized by chemicals and soaps, it is best practice among pediatric and adolescent gynecologists to recommend the use of water only (no soap) when cleaning that area[1]. Fortunately, feces usually do not go up inside the labial folds, but when it does, a wet cloth or wet paper towel should be used to gently clean the area, not a baby wipe. However, a wet paper towel is preferable because it can be disposed of. 1. S. Jean Emans, "Vulvovaginal Problems in the Prepubertal Child," in Pediatric and Adolescent Gynecology, 5th edition, ed. Marc R. Laufer and Donald Peter Goldstein (Lippincott Williams & Wilkins, 2005), 83.
Updated 12/8/2011	***Chapter 3*** Health Promotion Standard 3.2.1.4: Diaper Changing Procedure p.106	I am concerned with the change about the provider using an antibacterial wipe or hand sanitizer on hands instead of a diaper wipe. While it is good in theory, I do not feel it is safe. If the provider uses hand sanitizer correctly, the provider would need to have both of her hands off the child for 15 seconds while she is rubbing her hands together. This worries me because the child could fall off, plus if the provider isn't careful, the hand sanitizer could get on the child. For those children under the age of 24 months, the provider would need to use antibacterial wipes on the child's hands since they could not have hand sanitizer applied to them due to their age, so for those under 24 months who mouth their fingers, would the residue from the wipes be safe to ingest?	A primary consideration when changing a diaper is to ensure that the child is secure during the entire process including when hand hygiene is performed. If the caregiver/teacher uses hand sanitizer, the child should be secure and the hands dry before contact with the child. The use of wipes is preferable to hand sanitizers when cleaning the hands of children less than 24 months of age. Research on whether or not the residue from the wipes is safe to ingest is limited, but at this point, there is not any evidence to suggest that it is harmful.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion Standard 3.2.1.5: Procedure for Changing Children's Soiled Underwear/Pull-Ups and Clothing p. 108	Should a distinction be made between "wet" and "soiled" pull-up, clothing, and underwear? Or are these terms interchangeable in the Standard and Rationale? More specifically, are the steps required for changing a pull-up with a bowel movement the same for changing a pull-up that is only wet?	The same changing procedure should be used regardless of the contents.
10/13/2011	***Chapter 3*** Health Promotion 3.2.2 Hand Hygiene pp.110-116	Are alcohol-based hand sanitizing agents an effective alternative to soap and running water in situations other than field trips, such as in a classroom without a sink or on the playground?	The use of alcohol-based hand sanitizers is an alternative to traditional handwashing with soap and water by supervised children **over 24 months of age and adults on hands that are not visibly soiled if all manufacturers' instructions are followed.** For visibly dirty hands, rinsing under running water or wiping with a water-saturated towel should be used to remove as much dirt as possible before using a hand sanitizer. But if running water is necessary before sanitizer, one may as well just clean hands using soap and water.
10/13/2011	***Chapter 3*** Health Promotion 3.2.2 Hand Hygiene pp.110-116	This appears to be a significant change since the last *CFOC* edition. Can wet wipes be used to clean infant's hands or is running water and soap recommended?	Pre-moistened cleansing toilettes do not effectively clean hands and should not be used as a substitute for washing hands with soap and running water.
10/13/2011	***Chapter 3*** Health Promotion Standard 3.2.2.2: Handwashing Procedure p.111	This standard recommends that children and staff members rub their hands with a soapy lather for at least 20 seconds. Why was this changed from 10 seconds?	This recommendation follows the recommendation of the Centers for Disease Control (CDC). This reference can be found at: http://www.cdc.gov/handwashing/.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Standard 3.2.2.5: Hand Sanitizers p.113	Is there evidence to address the flammability risk of hand sanitizers and the recommended counter-measures with this product?	Hand sanitizers are flammable as noted on product labels. Standard 5.5.0.5: Storage of Flammable Materials (p. 256) was updated in the 2nd printing of *CFOC3* to address that hand sanitizers in volume should be stored in a separate building, in a locked area, away from high temperatures and ignition sources, and inaccessible to children.
10/13/2011	***Chapter 3*** Health Promotion 3.2.2 Hand Hygiene pp.110-116	Can single-use towels be used to dry hands if they are laundered with each use?	Yes, but they should not be made available to other children after use.
10/13/2011	***Chapter 3*** Health Promotion 3.3 Cleaning, Sanitizing, and Disinfectant pp. 116-118	Are disinfectant products "stronger" than sanitizing agents, i.e. do they kill more "germs?"	Yes and that is why there is a distinction. It is safer for some surfaces to be disinfected and not just sanitized. Please see Appendix J: Selecting an Appropriate Sanitizer or Disinfectant (p. 440) for specific definitions.
10/13/2011	***Chapter 3*** Health Promotion 3.3 Cleaning, Sanitizing, and Disinfectant pp. 116-118	Also, there seems to be a lot of interest in the use of "green" cleaning and sanitizing products. Many Early Childhood Education (ECE) programs have voiced a concern with the use of bleach solutions. Are properly diluted bleach solutions harmful to children's health? Are there safer and more effective alternatives, such as hydrogen peroxide based sanitizing agents or other products?	It only is proper dilution required, but also proper application and ventilation are required to reduce the risk of harm to children. Bleach used in this way is not harmful to children's health. Please see Appendix J: Selecting an Appropriate Sanitizer or Disinfectant (p. 440) for specific information. If a product that is not chlorine bleach is registered with the EPA and described as a sanitizer or as a disinfectant and is used according to the manufacturers' instructions (including proper application, drying time, ventilation, etc.), it can be used in child care settings, and can be as safe as bleach. Please see Appendix J: Selecting an Appropriate Sanitizer or Disinfectant (p. 440) for more specific information on this issue.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion 3.3 Cleaning, Sanitizing, and Disinfectant pp. 116-118	What do I tell child care providers about bleach solutions? Should they be changing the strengths as mentioned in *CFOC3* and do they need several strengths?	This is a different recommendation from *CFOC,* 2nd Ed. It was the consensus of the technical panel experts that *CFOC3* differentiate between sanitizing and disinfecting to reduce the spread of infectious diseases in child care settings. Please see Appendix J: Selecting an Appropriate Sanitizer or Disinfectant (p. 440) for specific information.
10/13/2011	***Chapter 3*** Health Promotion Standard 3.4.3.2: Use of Fire Extinguishers p.123	Should all teaching staff be trained to use fire extinguishers or should the focus be on evacuating (maybe having facility staff training in use?)	Staff should be trained that the first priority is to remove the children from the facility safely and quickly. Putting out the fire is secondary to the safe exit of the children and staff. The staff should demonstrate the ability to locate and operate the fire extinguishers.
10/13/2011	***Chapter 3*** Health Promotion 3.4.5 Sun Safety and Insect Repellant pp.126-128	Are Picaridin and IR3535 “safer” alternatives to *N*,*N*-Diethyl-*meta*-toluamide (DEET)?	*CFOC3* does not provide a distinction.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion 3.6.3 Medications pp.141-144	Are the 5 right practices of medication administration still current practices?	Yes, with added steps. These are the seven steps of medication administration (see page 143): a. Check that the name of the child on the medication and the child receiving the medication are the same; b. Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child's name; c. Read and understand the label/prescription directions or the separate written instructions in relation to the measured does, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and the other special instructions relative to the medication; d. Observe and report any side effects from medications; e. Document the administration of each dose by the time and the amount given; f. Document the person giving the administration and any side effects noted; g. Handle and store all medications according to label instructions and regulations.
10/13/2011	***Chapter 3*** Health Promotion 3.6.3 Medications pp.141-144	Is it necessary to have both a parent release and primary care provider's written permission for the use of over-the-counter (OTC) medications?	Yes, with the exception of non-prescription sunscreen and insect repellant. These require only parental consent (see page 142).
10/13/2011	***Chapter 3*** Health Promotion 3.6.3 Medications pp.141-144	Is it necessary for a staff member to receive medication administration training to apply sunscreen and/or insect repellent? What about non-prescription diaper cream, lotion or lip balm?	No.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 3*** Health Promotion 3.6.3 Medications pp.141-144	Is a standing order written by a health care provider for program-wide use appropriate or is it best practice to require a written standing order for each individual child?	A written order for each individual child is best (see page 142).
10/13/2011	***Chapter 3*** Health Promotion 3.6.3 Medications pp.141-144	Should ECE programs prohibit the use of cough and cold medication for children under 6 years of age or are there some instances in which a primary care provider might recommend their use?	Cough and cold medication is not recommended for children under the age of six. An ECE program would need written orders from a health care provider and parent/guardian permission to administer (see page 142).
CHAPTER 4: Nutrition and Food Service			
10/13/2011	***Chapter 4*** Nutrition and Food Service 4.2 General Requirements pp.152-162	Should programs be encouraged to serve fresh fruit and vegetables and "whole" foods with minimal ingredients, versus canned, frozen or processed foods?	"Whole" fruit is more nutritious than canned, frozen or processed fruit, but these varieties are allowed.
10/13/2011	***Chapter 4*** Nutrition and Food Service 4.2 General Requirements pp.152-162	Should canned fruits with sugar be restricted under the juice restrictions?	Foods with added sugar should be limited. Also, the juice that the fruit is packed in should be discarded and not served as juice.

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Date	Topic & Location	Question	Answer
10/17/2011	***Chapter 4*** Nutrition and Food Service Standard 4.3.1.3: Preparing, Feeding, and Storing Human Milk p.165	I cannot find any information in the new CFOC as to how long a bottle of breast milk can be kept after it is fed to an infant. It states that a bottle of formula should be discarded after one hour. I would think that it should be the same, since saliva is introduced into the bottle regardless of its contents, but I want to make sure. I would appreciate some guidance.	This Standard provides two references at the end of the "Guidelines for Storage of Human Milk" chart on page 166. Both resources state that breast milk should be discarded after it is fed to an infant. 1. The Academy of Breastfeeding Medicine Protocol Committee states: "Milk left in the feeding container after a feeding should be discarded and not used again." 2. The Centers for Disease Control (CDC) states: "Do not save milk from a used bottle for use at another feeding." A specific amount of time is not given (similar to the formula standard). The milk could be used again if it's the *same feeding* (for example, if the infant takes a short break from eating), but if it is clearly a different feeding, it should be thrown away.
10/13/2011	***Chapter 4*** Nutrition and Food Service Standard 4.3.1.8: Techniques for Bottle Feeding p.170	Can infants who are able to sit and hold their own bottles feed themselves or should all infants through 12 months be held during feedings?	Infants should always be held for bottle feeding. Caregivers/teachers and parents/guardians need to understand the relationship between bottle feeding and emotional security (see page 170).
10/13/2011	***Chapter 4*** Nutrition and Food Service Standard 4.3.1.9: Warming Bottles and Infant Foods p.171	I have concerns about the standards recommending glass and ceramic containers due to concerns about using plastic. Once again, it is good in theory, but I don't feel it is safe. I had a center that had a glass bottle drop and shatter in their infant room.	BPA-free plastic bottles, those labeled #1, #2, #4, or #5, can be used to avoid the use of glass. For those child care and early education facilities that choose to use glass bottles, a relatively new option is to use a bottle sleeve with the glass bottle to reduce the risk of shattered glass. Efficacy on this product is still being proven. Overall, glass is safer than plastic with BPA.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 4*** Nutrition 4.6 Food Brought From Home pp.182-183 4.8 Kitchen and Equipment pp. 185-188	Can families bring solid food prepared at home for use by an individual infant or is it only acceptable for families to provide the program with infant food in factory-sealed container (i.e., baby food jars)?	Solid food prepared at home is acceptable. The food should have a clear label showing the child's full name, the date, and the type of food.
10/13/2011	***Chapter 4*** Nutrition 4.6 Food Brought From Home pp.182-183	Can food brought from home for birthdays/celebrations be shared amongst children? If so, can it be home-made or must it be in a factory-sealed container/whole fruit/vegetable/prepared in restaurant/bakery?	The facility, in collaboration with parents/guardians and the food service staff, should establish a policy on foods brought from home for celebrating a child's birthday or any similar festive occasion (see page 182). In some states, food prepared at home may be prohibited. Thus, it is important to follow the state health department's requirements.
10/13/2011	***Chapter 4*** Nutrition 4.8 Kitchen and Equipment pp. 185-188 4.9 Food Safety pp. 188-195	Would it be best practice for the program to prepare fresh infant food in the program's kitchen, which would likely be appropriately regulated?	Yes. Please see Standard 4.8.0.1: Food Preparation Area (p.185) for guidance on food preparation areas, and 4.9 Food Safety (p. 188) for more specific information on this issue.
CHAPTER 5: Facilities, Supplies, Equipment, and Environmental Health			
10/13/2011	***Chapter 5*** Facilities Standard 5.1.1.5: Environmental Audit of Site Location p.200	Has the recommendation for minimum distance between a playground site and hazards, such as electrical transformers and high voltage power lines changed since the *CFOC,* 2nd Ed., which stated 30 feet?	Yes, specific distances are no longer recommended as distances may differ according to local municipalities and states. Please consult your local ordinance for appropriate information.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 5*** Facilities 5.1.2 Space Per Child pp.203-204	Generally, what is the rationale for the change in recommendation from 35 to 42 or 50 square feet of usable indoor space per child?	The standard of providing a minimum of 35 square foot of classroom space per child is not empirically supported. Research studies informed the change in standard to 42-50 square feet per child. Please see the references in Standard 5.1.2.1: Space Required Per Child (p.203) to read more about this research.
10/13/2011	***Chapter 5*** Facilities 5.2.1 Ventilation, Heating, Cooling, and Hot Water pp.211-217	If a Material Safety Data Sheet (MSDS) is prepared by the manufacturer of the chemical/product, are they reliable sources of information?	Yes.
Updated 12/14/2011	***Chapter 5*** Facilities 5.2.4 Electrical Fixtures and Outlets pp. 219-220	Should older outlets with plastic covers be replaced or phased out? Would there be any exemptions for programs with older facilities that have not recently completed facility renovations?	Older outlets with plastic covers should be replaced and updated. There are no exemptions to the standards. Although, local ordinances should be taken into consideration.
Updated 12/14/2011	***Chapter 5*** Facilities 5.2.5 Fire Warning Systems p.221	Is it reasonable to require fire extinguishers, fire alarms and smoke detectors in each classroom if children often sleep in the classroom?	Yes, depending on the type of facility. Smoke detectors/alarms should be placed in the following areas: a) each story in front of doors to the stairway b) corridors of all floors; c) Lounges and recreation areas; d) Sleeping rooms. However, in large and small family child care homes, single-station smoke alarms are acceptable. Fire extinguishers should never be accessible to children. Local fire department codes should be followed as well.

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Date	Topic & Location	Question	Answer
Updated 12/14/2011	***Chapter 5*** Facilities 5.2.7 Sewage and Garbage pp.225-226	Should garbage receptacle for used diapers be located in a room that is separate from the play area or in the closet?	The garbage receptacle should be kept in the diaper changing area so it is convenient and accessible for the caregiver/teacher during diaper changes. The outside of the garbage receptacle must be kept clean and the contents kept out of reach of children. Children must be closely supervised whenever in close proximity of the diaper changing area/receptacle.
10/13/2011	***Chapter 5*** Facilities 5.2.9 Prevention and Management of Toxic Substances pp.228-237	What labels should programs be looking for to ensure that art materials are safe if labels that states "non-toxic" are not reliable? Is there a seal of approval or certification through the Art & Creative Materials Institute, Inc. (ACMI)?	The ACMI AP (Approved Product) Seal, with or without Performance Certification, identifies art materials that are safe and that are certified in a toxicological evaluation by a medical expert. The seal is currently replacing the previous non-toxic seals (see page 232).
Updated 12/14/2011	***Chapter 5*** Facilities 5.2.9 Prevention and Management of Toxic Substances pp.228-237	Would a certified playground safety inspector check for things like treatment of Chromated Copper Arsenate (CCA)-pressure treated wood when conducting an inspection?	Yes, a Certified Playground Inspector would look for CCA-pressure treated wood during their inspection. Both the ASTM International Playground Standards and Consumer Product Safety Council (CPSC) Guidelines recommend against the use of CCA-pressure treated wood on public playgrounds.

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Date	Topic & Location	Question	Answer
10/13/2011	***Chapter 5*** Facilities Standard 5.3.1.4: Surfaces of Equipment, Furniture, Toys, and Play Materials p.239	Do all pressed wood items contain formaldehyde?	All pressed wood items do not contain added formaldehyde; however, all wood naturally contains some formaldehyde. Pressed wood products that have the highest formaldehyde emissions are those that are made with urea-formaldehyde resins. Products designed for interior use, such as hardwood plywood, medium density fiberboard, and particleboard, are more likely to contain urea-formaldehyde than those designed for exterior use such as oriented strand board or structural plywood. However, hardwood plywood, medium density fiberboard, and particleboard don't necessarily contain added formaldehyde; they are sometimes made with no added formaldehyde based resins. Many companies are choosing to make products with no added formaldehyde (NAF) based resins as well as ultra low-emitting formaldehyde (ULEF) based resins both to market their products as green and to comply with California regulations on composite wood products. Some products are currently labeled as made with NAF or ULEF resins under the California regulations, and once EPA regulations are proposed and go into effect, more products will be labeled to inform consumers about formaldehyde content.

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