WELCOME TO INFANTS

Welcome to the Infant Bungalow of University of Minnesota Child Development Center. This document describes for families and staff the unique features of our Infant Program. Please read it carefully and keep it with other UMCDC information so that you may refer. We want you to feel a sense of trust and security while your child spends his/her day with us at UMCDC. We welcome your questions, input, or suggestions. A copy is in the bungalow foyer on the Family Information Board.

INFANT BUNGALOW

The infant bungalow is composed of two classrooms that are identical in facility design, staffing, group size, and caregiving practices. The two rooms are divided by shared spaces that include a diaper change room, mother’s nursing room, kitchen, and Area Coordinator’s office. During the early morning arrival and late afternoon departure times, the groups merge in the one of the two classrooms.

Please wash your child’s hands before introducing your child into the group of children. This is, also, the time to sign your child in and out, fill out and read the daily sheet, and store belongings your infant’s cubby. On either side of the foyer is an adult bathroom, laundry room and sleep rooms. It is our practice, for the comfort of your child, that you ensure they/he/she is transitioned to care with your assistance to be assimilated into the group. We work with you to establish a routine to do so. This is the age of building attachment and relationship, so we ask that you establish a caring routine and do not rush off or sneak out.

STAFFING AND CHILDREN

The infant area is composed of two groups of nine infants, ranging in age from three months to approximately sixteen months. We advise a shorter day for infants, not to exceed eight hours in care. It is over tiring and over-stimulating for them. We suggest your infant back into your care within this shorter time frame than the hours that we are open. Ratios, child to caregivers: the state minimum requirement is a ratio of 1:4, but we believe a ratio of 1:3 is necessary for high quality care of such young children. We maintain a developmentally appropriate staff to child ratios and group sizes during all parts of the day, including indoor and outdoor times. Our staff includes:

• One full time Area Coordinator who supervises and manages the bungalow
• Two full time Teachers - one for each classroom
• Two full time Assistant Teachers – at least one for each classroom
• One floating 75% to full time Assistant Teacher
• Child Care Workers (CCWs) - U of M undergraduate students who are carefully screened and oriented

DAYS AND HOURS OF CENTER OPERATION

UMCDC is open from 7:30 a.m. until 5:30 p.m. Monday through Friday throughout the calendar year. The center is closed on all University holidays and eight staff development days. The list of closed days may be found in the back
of the Parent Handbook, in the Enrollment Packet, or on our website. Infants, as stated before do better with shorter days in group care.

TEAM TEACHING APPROACH

The Area Coordinator is responsible to model and demonstrate best practices in each infant room and will spend time in each group on a daily basis. Each classroom has a full-time Teacher, an Assistant Teacher and Child Care Workers (CCWs) to maintain the 1:3 staff-to-child ratio.

The Area Coordinator in each bungalow is responsible for the overall running of the bungalow, scheduling of staff, consonance with program planning, and supervision of all staff in the bungalow. Throughout the week, the Area Coordinator spends time in the two classrooms observing, supervising, modeling and demonstrating interactions and best practices to support development of the children and to support the teaching staff. Area Coordinators use current Early Childhood Research to support teachers in their classrooms. The Area Coordinator works closely with the full time teachers to discuss and meet children’s individual and group needs, to set goals, and make decisions.

Each classroom has a full time Teacher and Assistant Teacher who work closely as a team to plan developmentally appropriate curriculum, materials, and discuss individual and group needs, and share ideas or web. The team shares in the care of all of the children and the maintenance of the environment.

Student Child Care Workers (CCW’s) are assistants to the teachers in the classroom. Their responsibility is to assist the teachers in all parts infant daily care and development. Each new student is interviewed by the Education Coordinator, and then spends two hours in a classroom under supervision. This ‘probation’ period gives teachers a chance to see how students interact with young children and staff. When a CCW gets assigned hours in Infants, they receive training in Abusive Head Trauma, SUID, Mandated Reporting, risk reduction, and receive a general orientation to classroom routines and procedures of feeding, diapering, napping.

CAREGIVING APPROACH

We view the infant area as a close-knit community where attachments/relationships between caregivers and the infants in their care are encouraged and supported. As the infants become comfortable, we broaden their exposure to more staff and new experiences. We work to develop an interactive and trusting relationship, i.e. a “partnership of caring” with families. We want to work with you for optimal care of each individual and for the group.

SUPERVISION OF CHILDREN

The health and safety of each child enrolled at the center is our primary concern and responsibility. Careful supervision of children is practiced consistently throughout the program. The building’s design allows teaching staff to keep children within sight and sound at all times. Windows allow staff to visually supervise children in the nap rooms and diaper area from the classrooms.
Opening and closing doors to and in the bungalow are considered a “grown-up’s” job.

Dutch doors enable staff to hear and see children and supervise staff in sight and sound at all times. All full and 75% time staff are trained in CPR, OSHA, HIPPA, First Aid, AHT and SUIDS are prepared to prevent or treat injuries as needed.

When a child experiences an injury such as a bump or bruise from a fall, an injury report is filled out in triplicate, explaining the circumstance, the nature of the injury, and the first aid administered. If the injury is a bump to the head, a head injury report is included with the injury report. It is not unexpected that incidents to occur in this age group as they roll over, crawl, learn to walk, and encounter steps and ramps.

**SIGN IN AND OUT**
You MUST sign you child in and out daily. It is a MN DHS licensing requirement. This allows us to keep accurate records of who is in attendance, which is very important in the event of an emergency or any time we move from one area to another. To ensure we have a correct child count we use a face to name, child count process.

**EMERGENCY CARDS**
Keep your emergency card current, it is a mandate of MN DHS licensing. Updates are done at the front desk. If your child becomes ill or injured, we will make every effort to reach you. If you aren’t available, your other contact persons will be called. If your child becomes ill at the center, you must pick up your child within one hour of the time we contact you. We are not licensed for “sick” childcare as per our MN DHS licensing.

**MEDICATION**
We will not dispense medications unless you complete a medication Permission Form for the prescribed medicine(s). We must have the physician’s instruction (doctor’s order) s, as well as your authorization, for all prescription and non-prescription medications, oral or topical. The meds must be in the original containers (considered a doctor’s order). Please refer to your UMCDC Parent Handbook for more information regarding requirements re illness and medications.

**SAFE SLEEP POLICY AND PROCEDURE**
Are mandated and all infant staff are trained in Sudden Unexpected Infant Death (SUID) prevention and Abusive Head Trauma (AHT). Infants in the nap room are within sight and sound of at least one staff at all times. Staff will be positioned in the nap room when a sleeping infant is in the nap room. Only, in staffing does not permit this safely, the child’s crib will be moved into the classroom. When four or more infants are in the nap room the staff member will open the nap room door and another staff member in the classroom will keep the nap room in their eyesight to provide extra help as needed.

An individualized crib is provided for each infant in our care. Each crib is of safe and sturdy construction that conforms to federal crib standards under
Code of Federal Regulations, title 16, part 1219 for full-size baby cribs. The license holder must place each infant on their back in a crib on a firm mattress with a fitted sheet that is appropriate to the mattress size that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place anything in the crib with the infant except for the infant’s pacifier, as defined in Code of Federal Regulations, title 16, part 1511.

Reduction of risk of sudden unexpected infant death: Pursuant to Minnesota Statutes, section 245A.1435, the license holder must place each infant to sleep on the infant’s back until the infant is over twelve months of age. Unless the license holder has documentation from the infant’s physician directing an alternative sleeping position for the infant. The physician directive must be on a form approved by the commissioner and must remain on file at the licensed location. An infant who independently rolls onto its stomach after being placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant is at least six months of age and the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

If an infant falls asleep before being placed in a crib, the license holder must move the infant to a crib as soon as practicable, and must keep the infant within sight of the license holder until the infant is placed in a crib. When an infant falls asleep while being held, the license holder must consider the supervision needs of other children in care when determining how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant must not be in a position where the airway may be blocked or with anything covering the infant's face.

SLEEP SACKS and PACIFIERS

UMCDC will provide a Sleep Sack for the infant if the parent desires. We use the Halo brand sleep sack and will adjust the size as the infant grows. We will also provide the pacifier for the infant, if the parent desires.

MEETING INDIVIDUAL NEEDS

We are very aware that each child has individual needs and personalities, and we try to meet their needs for social, emotional, and physical health. As the family enters our program, the Area Coordinator schedules an intake with the parents to gather information about the individual needs and approximate schedule of the new infant. We want to know the details about your child that parents are best at knowing: for example, how an infant likes to be held, what they eat, and how they go to sleep. These are helpful pieces of information. We also rely on daily communication and scheduled parent conferences to help us know and serve each individual child, to establish and maintain a partnership of caring. As we are a richly diverse center, please share any cultural practices that we may be unaware of.

Daily Charts:

When you arrive to drop your infant off, please complete the daily chart for your child. This provides us with information on how your child slept, when they
last ate and other important information. Teachers will record information about your child’s day also. We record nap times, food intake, and any anecdotal observations made by the teachers.

**PHILOSOPHY/CURRICULUM**

In the UMCDC Infant Area, the term “curriculum” is incorporated into routines, such as, play, diapering, sleeping, feeding, and interactions that the children have with other children, staff, and with their environment.

We follow a developmentally appropriate approach to routines, play, materials and learning. Teachers observe to be aware of the emerging changes children are going through physically, cognitively, emotionally, and socially and then facilitate appropriate activities and experiences in each area. Play offers infants opportunities to become involved in open-ended exploration and build relationships. Through play, infants explore, make discoveries, work on problems, make choices, and find out what kinds of things interest them, learn to repeat, focus, persist, and develop strategies and understand things like “cause & effect.”

Routines are considered part of our curriculum. Diapering is looked upon as an opportunity for one-to-one interaction with the infant, to talk, encourage reciprocity, attachment and relationships, and to give your infant positive messages about his/her body functions. Interactions between staff and infants at feeding/mealtimes promote relationship, nutrition, sensory experiences, and the development of motor and self-help skills.

The interactions that children experience with the staff and with their environment are the third part of our curriculum. We work to create a nurturing learning environment. Infants have many needs and require adults who are there for them; to provide support through talking, singing, language (and some ASL sign language), reading, and playing. Sensitive observers and caregivers respond to the infants’ needs for food, sleep and play based on their individual schedules. Our goal is to have an atmosphere that sets an ambient tone that is warm, positive and respectful to each infant. We want infants to develop a sense of trust, well-being, competency, and high self-esteem that come by forming trusting, positive, warm relationships with caregivers who understand the needs of infants and who sincerely enjoy working with them. When infants feel secure with the staff and the environment, they are able to freely explore and meet new challenges. As infants play, the teachers provide appropriate learning materials and guiding support as they discover how they can interact with and have an effect on their own environment. What this means for the teacher is to allow the child time to work out obstacles, motor or “cognitive knots” (i.e. being stuck under the table) or to experience interaction with another child (i.e. both infants pulling on the same toy), and not to immediately rescue them. Teachers intervene if the child seems unable to find success or resolution with the situation. We combine a positive, caring attitude with knowledge of early child development and respect for each individual in order to provide the best possible care for the infants we serve. Teachers plan and follow daily routines so infants can both anticipate and participate in predictable activities.
CENTER PHILOSOPHY

UMCDC is based on socio-cultural and social constructivist theories and inspired by the schools of Reggio Emilia and Pistoia, Italy. The Center is accredited by the National Association for the Education of Young Children, NAEYC with which UMCDC practices are aligned. Some examples of the theoretical work on which the center draws are Lev Vygotsky, Jean Piaget, Erik Erickson, Urie Bronfenbrenner, Alice Honig, Janet Gonzalez-Mena, Lillian Katz, Kyle Pruett, Allison Gopnick, Caralini Rinaldi, Carolyn Edwards, Lella Gandini, Ron Lally & Peter Mangionne (at West Ed/PITC).

Teachers see themselves with children as facilitators, co-researchers and co-constructors of knowledge in the domains of psychosocial, motor and cognitive development. Teachers develop and create “emergent” curriculum around children’s interest(s), observations, assessment and their knowledge of development. Thus, the curriculum is a balance of teacher and child initiated projects and activities. Teachers view children from the perspective of an asset model that is children are born with curiosity, a desire to learn. The role of caregivers (teachers & parents) is to observe and assist nature in development.

The physical Environment is intentional and incorporates natural elements. It is meant to be sensory rich and engaging to children. Simultaneously, the Bungalows are homey; walls, shelves and closet areas are organized and uncluttered, materials are selected by teaching staff and area coordinators with intentionality. Like cities in Italy, the environment is seen as the third teacher. Therefore, attention is given to the bungalow foyer, play castles, classroom(s), play yards, to lightscapes, natural elements e.g. plants, furniture, equipment, materials and activities.

Curriculum provides a framework for developmentally appropriate experiences, encounters and investigations to engage infant’s both indoors and outside, to give them opportunities to explore, problem solve and investigate. In infancy curriculum is primarily embedded in routines, relationships and motor development. In toddlerhood, time is given to curriculum based in play, psychosocial and cognitive domains while continuing to work on a variety of motor skills. For children in pre-k there is a new mastery and sense of competence from the earlier years, which leads to an increase in cognitive domain activities and small group projects. As stated in the teacher section, curriculum is responsive to children’s interests and needs while balancing and developing appropriate curriculum to meet the stated goals of the program.

Readiness is looked at developmentally. The indicators in the assessment tool, “Desired Results Developmental Portfolio (DRDP)”, are progressive and give a picture of each child’s progression. A significant indicator of readiness and of success throughout life is self-regulation. This includes perseverance, the ability to wait, to meet one’s own and another’s needs, to share, and to self-calm. We assist in the development of self-regulation and readiness with routines so that children can anticipate, thus helping them to wait, to learn some ways to self-
calm and by setting boundaries that make children feel safe and secure, mentally and physically. Through our interactions, routines, explorations, guided activities and small group projects we exercise their skills.

ANTI-BIAS AWARENESS

We strive to create a classroom that is free of bias as it relates to race, creed, gender, culture, age, family type, socio-economic class, abilities, etc. Our goal is to help prevent stereotyping and to help the children recognize the uniqueness of each individual and the diversity of our society. Our approach to this accomplishment is through interactions, conversations, and materials: books, puzzles, pictures, furnishings, music, etc. We respect all children and adults. We need your help and support to model this. If you know of materials, resources or have any suggestions, or would like to share something of your culture, please talk with us about sharing.

COMMUNICATION AND LANGUAGE ACQUISITION

Communication and language have an essential role in all areas of our curriculum. We support language growth and cognitive understanding by using “self-talk and parallel talk” and narration. This means we tell the infants what they are doing or what we are doing in descriptive words. We also use some ASL, American Sign Language during routines and play times. When we are preparing to change an infant’s diaper, we tell them verbally and sign what we are planning to do, so the infant can begin to anticipate what is going to happen. Explaining events that are going to happen, or as they happen, helps the infants learn about themselves and their world. They also learn they can have some control as they participate in their own care.

We encourage the infants to communicate with us, offer and engage. When a young infant cries, we respond by trying to determine what they need or want. As the children learn that people will respond to their efforts, they can become more skillful in conveying their needs. We imitate their sounds so they can learn to exchange vocalizations with others. We also use simple Baby Signs to add another layer of communication and sensory input.

As the infants get older, they begin to use signs and sounds that we recognize and reinforce. We acknowledge and respond to their attempts at communication to encourage language development. These curriculum approaches are intended to facilitate the young child’s ability to understand language, to communicate, to develop and maintain a deep sense of basic trust in their caregivers and environments.

PARENT/TEACHER CONFERENCES and ASSESSMENTS

Throughout your child's enrollment in the infant area, we will have opportunities for parent/teacher conferences. The first will be an Intake Conference, when the Infant Area Coordinator orients you to the area and gives you this Infant Area Child Care Program Plan for you to keep to review and read on your own. Also at this time, an intake form is filled out with specific information about your child to help inform and support staff in efforts to care for your child.
The second type of conference is when your child’s development is assessed and discussed. The first assessment is done within 60 days and a conference within 90 days of your start. The Area Coordinator will work with you to find a time that works with both the Teacher’s and your schedule to schedule a conference. When you have a conference, you will be meeting with the teacher. Occasionally, the Area Coordinator will join in. During a conference, the teacher will discuss with you the progress your child has made within the assessment tool. You will be asked to fill out and return a Parent Input Form before you meet with the teacher for your conference. The Input Form is very useful input and is used as a collaborative tool to create new goals and discuss your child’s strengths and any possible concerns. You can always request the Area Coordinator to be a part of the conferences. Please, do this when you are informed of a conference so we can schedule for ratios.

There are six goals that the DRDP, Desired Results Developmental Profile, is based on. The staff develops curriculum and scaffold plans to help the children work towards these goals. The goals are:
1. Children are personally and socially competent
2. Children are effective learners
3. Children show physical and motor competence
4. Children are safe and healthy
5. Families support their children’s learning & development
6. Families achieve their goals.

Within these goals, five domains are placed that represent the areas of learning and development. These domains are: Self and Social Development (SSD); Language and Literacy Development (LLD); Cognitive Development (COG); Motor and Perceptual Development (MPD); and Health (HLTH). Under each domain, there are measures that guide the staff to show evidence of what and how the children are learning and developing.

Assessment is done naturally, that is, children are never put in a “testing” situation. By this, we mean that these ways we assess are done while the children are at work or play. The social, emotional, self-help, gross motor, fine motor, and language progress of each infant is documented on a standardized Desired Results Developmental Profile. The information from this development chart is then written up on a summary sheet and expanded upon during the conference. Documentation with photographs and anecdotes of each child’s learning, development, and exploration is done regularly and kept in a binder. It is presented to parents at approximately sixty days, and six-month intervals through parent/teacher conferences. Either parents or staff can also request additional conferences. The assessment tool (Desired Results Developmental Profile) is kept in a binder for your child. Please note: binders never leave the Center. However, you will be given a copy when your child goes to Infants or leaves UMCDC. These binders and the evidence within are shown to you during a conference with your child’s teacher. Parents are welcome to look at their child’s binder at any time, but it must stay within the center and be returned to the bungalow office. All binders are confidential and not shared among parents.
The third type of conference is offered when your child moves to Toddlers. This Outtake Conference reviews your child’s development, gives you information about the toddler area, shares pertinent information with the toddler staff, and gives closure to your experiences in the infant area.

**PARENT-TEACHER RELATIONSHIPS**

At UMCDC, we believe that parent-teacher relationships are an important component of our program. We recognize that parents and families are experts on their own children. We encourage parents and families to share their concerns and desires for care. And, to use the parent input form. In turn, we provide daily notes that address their infant’s food intake, sleeping patterns, general health, and behavior. These charts are kept for one week as a reference for the staff, and are photocopied and sent home with the parents at the end of each week.

Our goal is to balance the best interests of the total group with the individual needs of each child within our daily program confines and as dictated by national, (NAEYC) state (licensing), university, and center policies. Parents and families are welcome to come and visit their child at any time. This can be a valuable time to observe the child care setting in action, and gain a greater understanding of the dynamics of group care throughout the day. This can also be an opportunity to strengthen the partnership between families and staff, as well as to see how your child functions in a group setting.

**Procedures for Bottle Preparation, Mother’s Milk and Food Handling for Infants**

Special policies must be approved and followed, according to licensing and NAEYC requirements, for the handling of food served to infants, including breast milk and infant formula. All staff must follow these policies, as well as parents and families who handle food at UMCDC. These policies are kept posted by the food-serving areas in the infant program, and are as follows:

1. **Bottle preparation**  
   a. Wash hands with soap and water, following procedures posted at sink.
   b. Refer to bottle charts posted on the cabinet near the counter of Infant Area Kitchen, which lists which infants get which type of bottle, how much milk or formula, etc.
   c. Cow’s milk is in the Infant Area Kitchen refrigerator. Powder Formula is on the counter, with unopened packages available in the cabinet.
   d. Bottles should be labeled with infants’ full names, the date and what the bottle contains. (EX: Mary Smith, 1/1/16, Similac)

2. **Making formula**  
   a. Formula is on the counter, with unopened packages stored in the cabinet.
   b. Use water from the kitchen faucet.
c. Add appropriate amount of formula powder. Use a clean scoop for each bottle.
d. Put the collar and nipple on the bottle; shake well.
e. Bottles may not have solid foods (cereal, etc.) added, as per Food Program rules posted on Meal Count Sheets.

3. Heating bottles [NAEYC criterion procedure]
a. Put eight ounces of water in measuring cup. Place the water in microwave, heating for one minute. Place thermometer in cup to check temperature. When warming formula or breast milk, the formula or breast milk is to be warmed in water at no more than 120 degrees Fahrenheit for no more than five minutes (NAEYC criterion 5.B.10.d). If thermometer reads higher than 120 degrees, water must be cooled to 120 degrees before putting bottle in the water.
b. Per OSHA requirements, we do not test temperature of breast milk on wrists; use the procedure above.

4. Serving of bottles:
The Area Coordinator trains all UMCDC Infant teaching staff on the labeling and preparation of Infant Bottles during orientation. All bottles are labeled with the child’s first and last name. The date the bottle was prepared, the contents of the bottle and the amount of fluid in the bottle. When prepping the bottle staff check the bottle for this information and add the time the bottle will be served. When handing off the bottle the staff member reads the bottle aloud. Prior to serving the bottle to the child, the staff member reads the bottle aloud and does name to face recognition.

5. Formula and jar food serving/storage precautions
a. After one hour, staff must discard any formula that is served but not completely consumed (NAEYC criterion 5.B.10.c).
b. Breast milk may be stored in the refrigerator no longer than 24 hours. UMCDC staff do not pour out leftover/unused breast milk, but leave it in the bottle for parents to take home and dispose of. After one hour of serving the bottle of breast milk, the same bottle may not be offered again.
c. No infant foods are warmed in the microwave.
d. Jar food is served from bowls, not directly from the jar.
e. When a jar of infant food is opened, the lid is labeled with the date and time. Unused jar food must be discarded after 24 hours of opening.
6. We encourage nursing your infant and having rockers in the room you can nurse in and/or for expressing milk we have and small separate room for you as well.

7. When your infant is ready for cereal we use Gerber brand Oatmeal and Gerber brand Fruit and Vegetable purees.

### INFANT BUNGALOW A DAILY SCHEDULE

#### 7:30-5:30 MONDAY TO FRIDAY

The children in the infant area follow a schedule that is unique for each child. The Family and Area Coordinator plan the schedule cooperatively. Each schedule is modified over time as the infant’s development and family’s desires dictate. Although each child’s development follows an individualized schedule, the pattern of the day is as follows:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 - 8:30</td>
<td><strong>Welcoming</strong> – Both A1 &amp; A2 join together in the classroom for free exploration, story time and beginning their day</td>
</tr>
<tr>
<td>8:30 – 10:00</td>
<td><strong>Breakfast and Bottles – Exploration of the Classroom</strong></td>
</tr>
<tr>
<td>10:00 - 11:00</td>
<td><strong>Teacher Directed Small Groups</strong> - Outside Play, Large Motor Room, or Flex Room or Foyer Activities</td>
</tr>
<tr>
<td>11:00 – 12:30</td>
<td><strong>Lunch and Bottles – Exploration of the Classroom</strong></td>
</tr>
<tr>
<td>12:30-2:45</td>
<td><strong>Teacher Directed Small Groups</strong> - Outside Play, Large Motor Room, or Foyer Activities</td>
</tr>
<tr>
<td>2:30-3:15</td>
<td><strong>Afternoon Snack and Bottles – Exploration of the Classroom</strong></td>
</tr>
<tr>
<td>3:00-4:30</td>
<td><strong>Child Initiated Free Play and Exploration both Indoors and Outdoors.</strong></td>
</tr>
<tr>
<td>4:30-5:30</td>
<td><strong>Departure for the Day</strong> – Both A1 and A2 join in the classroom or the Infant Porch end of the day.</td>
</tr>
</tbody>
</table>

The family and the teaching staff as a team decide on Rest Times. Many children go down to an afternoon nap around 12 to 14 months of age.
Bottles, strained fruits & vegetables and cereal are offered on demand based on the Family’s schedule and the needs of the individual child.

Children are age eligible to transition to the Toddler Bungalows at 16 months old. Around 13 to 15 months, with the input of the family, teaching staff work to adapt the children’s schedule to match the Toddler Bungalows by offering meals sitting at a group of four children at a table.

This Child Care Program Plan for the Infant Area was developed by the Infant Area staff and is evaluated annually by the Area Coordinator, the Education Coordinator, and the Center Director as well as through parent questionnaires. This program plan is kept posted in the Infant Area room and is available for your review at any time.

**INFANT CURRICULUM – SAMPLE ACTIVITIES AND MATERIALS**

<table>
<thead>
<tr>
<th>AGE 3 MONTHS</th>
<th>AGES 3 TO 6 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal attention</td>
<td>Previous suggestions plus:</td>
</tr>
<tr>
<td>Eye to eye contact</td>
<td>Objects to hold and chew (soft rubber toys)</td>
</tr>
<tr>
<td>Sound imitating and talking to the infant, “self and parallel talk”</td>
<td>Infant seats</td>
</tr>
<tr>
<td>Exercises-legs, torso, rolling, twisting, etc.</td>
<td>Objects to shake</td>
</tr>
<tr>
<td>Music boxes</td>
<td>Objects to reach for, chains with hanging objects</td>
</tr>
<tr>
<td>Dolls</td>
<td>Busy boxes (beginning to notice)</td>
</tr>
<tr>
<td>Downward facing mobiles</td>
<td>Mirrors</td>
</tr>
<tr>
<td>Fabric or towels</td>
<td>Donut cushion (learning to sit)</td>
</tr>
<tr>
<td>Objects-eye tracking</td>
<td>Bubbles</td>
</tr>
<tr>
<td>Tactile stimulation- fabrics</td>
<td>Books (Fabric or Plastic)</td>
</tr>
<tr>
<td>Cuddling</td>
<td>Pyramid Mirror</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AGES 6 TO 12 MONTHS</th>
<th>AGES 12 TO 18 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous suggestions plus:</td>
<td>Previous suggestions plus:</td>
</tr>
<tr>
<td>Stacking rings</td>
<td>More complex cause-effect toys and activities – push buttons, levers, open-shut, poppers, push-pull toys, in/out, pouring/scooping</td>
</tr>
<tr>
<td>Stacking cups/Shape sorters</td>
<td>Puzzles</td>
</tr>
<tr>
<td>Large pop beads</td>
<td>Bean bags</td>
</tr>
<tr>
<td>Blocks</td>
<td>Music: movement, dancing, following directions</td>
</tr>
<tr>
<td>Boxes with tops</td>
<td>Large muscle: chairs to practice getting in and out of, more</td>
</tr>
<tr>
<td>Jumbo peg boards</td>
<td></td>
</tr>
<tr>
<td>Pop-In-pals busy box</td>
<td></td>
</tr>
<tr>
<td>Shakers</td>
<td></td>
</tr>
<tr>
<td>Bubbles</td>
<td></td>
</tr>
<tr>
<td>Textures</td>
<td></td>
</tr>
</tbody>
</table>
Books (board) or cloth
Music: songs, finger plays, instruments, dancing
Large muscle: barrels, ramp, slide, rocking boat, outdoor swing, push toys, etc.
Dramatic play: dishes, blankets, puppets, telephones, dolls and animals, cars and trucks
Simple games with “object permanence” and imitation: so big, peek-a-boo, clapping
Self-care: expressing needs, feeding self, using a spoon, using a cup, sitting down for a cup, pulling off socks
Mirrors
Light box
Flashlights

complex set-ups, obstacle courses, riding toys, buckets, and containers for carrying, chase games and dancing, balls, climber, pull toys, sand box, water play
Dramatic play: Dishes, dolls, cars and trucks, hats, purses, shoes, tents, blocks, cameras, phones
Art and sensory experiences: crayons, clay, chalk, water, sand, snow, paint, paper, playdough, noise-shakers, tubes
Processes: attending routines, tossing garbage, following directions, hand washing
Field trips to Toddler Bungalows/play yards, Multi-purpose room/Gym, Flex room, Flex play yard, porch and courtyard

PARENT RESPONSIBILITIES

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td><strong>Please sign in and out daily.</strong> Always indicate the time of day and initial.</td>
<td><strong>This is very important.</strong> Throughout the day, and especially in case of an emergency, we will use the sign-in sheet to verify which children are present. Licensing requires this procedure.</td>
</tr>
<tr>
<td><strong>As you arrive in the morning please fill out the daily form to give staff information about your child.</strong> How is his/her health? Any schedule changes today? Have there been any changes in your family life the past few days, which might affect your child? How did they eat, sleep? Who is picking them up, and when?</td>
<td><strong>What happens at home does affect your child at the center</strong> (i.e. change in eating or sleeping habits.). We can better meet you and your child’s needs when we work with you as a team. The morning update insures that all staff are informed. Our staff works more effectively with your child when we know of changes in their daily routine. Such things as “Mom is out of town” or “Grandpa was at our house” help us to be sensitive to the child’s feelings and actions.</td>
</tr>
</tbody>
</table>

Provide diapers, wipes, diaper ointment
We change the children numerous
and body lotion for your child.
We have room to store a large box or bag. Disposable diapers and wet wipes are required. We also offer the use of cloth diapers in limited numbers.

| Keep 3-4 complete changes of clothing here that are seasonally appropriate and the correct size (sleepers, or shirt, slacks, & socks). They must be labeled. Also label coats, hats, etc. All soiled clothing is sent home. | We do not launder any clothing that is soiled while your child is here. We have a laundry marker if you wish to use it for labeling. Please remember to return clothing to your child’s basket in the diaper room if you take clothing home. |
| Inform us of preferences for formula or milk. We purchase generic brands of formula. Parents have the option of bringing other brands if they choose. The center also provides soy, rice, and whole cow’s milk after the age of 12 months. Nursing moms are welcome to come to visit during the day to breastfeed their infant, and bring in expressed milk to be served at mealtime. All breast milk must be labeled with the infant’s full name and marked with the date expressed or thawed (if previously frozen). | We prepare the center bottles as needed. |
| Please read your child’s chart daily. We record your child’s feeding, napping and play behavior as the day progresses as well as notes about your child’s daily activities. | We will call you in case of an emergency, or if your child becomes ill at the center. Staff call parents and emergency contacts until someone is verbally contacted to inform them of the infant’s situation. |
| Keep your emergency card up to date with current phone numbers and contact information. Cards are updated at conferences. | |
If your child needs medication, fill out a medication form. The center will provide the forms.

We will dispense prescription medication with your written permission and the doctor’s permission and direction. Any non-prescription medication must be accompanied by a doctor’s direction for dispensing (this includes Tylenol and Ibuprofen).

Let us know if someone else will be picking up your child.

Record this on the chart and fill out an alternate pick-up form. We will not release your child to anyone except the people on the front of your child’s emergency card, or those you have told us to expect to pick up your child. Please inform any alternate pick-up person that staff will check photo identification.

Please notify staff if for any reason your child will be late or not coming in for the day. We ask to be notified by 9:30am. Emailing the Area Coordinator or calling the Infant Bungalow phone at 612-626-3179

We are concerned about your child and would like to know why absent children are not in attendance. We also want to be alerted to illness to enable us to watch for symptoms in other children.

Please ask if you have questions or concerns about your child’s care.

We try to maintain ongoing communication between staff and parents.

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**DEVELOPMENTALLY APPROPRIATE INFORMATION REGARDING BITING**

Biting is associated especially with older infant stages and many infants bite. We feel it is important to give you some information regarding an “unfortunately but not unexpected” occurrence among infants. Biting is not just a physical act. It is a complicated issue that brings frustrations to the biter; the one who was bitten, parents, and child care providers. The infant behavior that is “unfortunately not unexpected” conveys the understanding that while biting is not something providers or administrators want for the children in their programs, the staff are not surprised by biting among infants and are prepared to address it.

**Assumptions about Biting:** Most people see biting as a behavior problem that must be punished. According to this way of thinking, if there is no punishment, then the biter has “gotten away with it” and this cannot be allowed. This is not UMCDC’s policy for addressing biting incidences. Many parents, and a number of providers, may want the child who bit to have to ‘pay a price’ or be expelled
for biting. Punishment makes them (the adults) feel that in at least some small way, justice has been served. UMCDC’s program focuses on the needs of the children. We do not use techniques simply to satisfy the adults involved when those techniques (punishment) are, in fact, inappropriate or ineffective with small children. Research shows that punishment is not an effective response to any kind of behavior problem. It’s necessary to understand why infants bite and then find strategies and techniques that match the child’s reason or reasons for biting. UMCDC operates from a multi-dimensional perspective to biting that includes:

- Observation and documentation
- We understand and accept that when infants are in groups, biting is unfortunately not unexpected
- We know and accept that infants bite for many reasons.
- We believe that biting is never the right thing to do.
- We want to help the children who are bitten feel better by giving them care, support, and advice.
- We want children who bite to learn different, more appropriate behaviors.
- We understand that our care giving environment and practices can influence biting, and we take responsibility for ensuring the environment and practices are appropriate for infants.
- We understand that biting is very difficult for parents, and we communicate with them thoughtfully and frankly.

The Infant staff address this problem itself by looking at why infants bite, how to respond when they do, how to help both the child who is biting and the child who is being bitten, and how to develop a plan to deal with repeated biting. We want you to know that we have procedures in place to deal with this and other challenging behaviors.

Causes for Biting: It is very important to understand that many of the reasons for biting are related to development. It also puts biting into perspective: it points away from blaming infants for biting and towards understanding that while they are developing important knowledge and skills, biting is “not unexpected”. While many infants bite, the causes vary, and they often fall into three broad categories:

1. Developmental issues, such as: teething pain or discomfort, developing oral-motor skills, sensory exploration of the surroundings, learning about cause and effect, learning through imitating others, developing a sense of space, developing autonomy, developing, but perhaps lacking expressive communication skills, needing more attention, learning to hold on and let go, and developing sensory integration.
2. **Expression of feelings**, which may include: frustration, anger, tension, anxiety, excitement, or a reaction to abuse or other physical aggression or few ways to calm, bring down their arousal state.

3. **An environment that is not working for the child**, for example: an environment that is too stimulating or not stimulating enough, a space that is too crowded and does not allow children privacy, inappropriate expectations (Such as expecting infants to share toys or equipment), or a rigid schedule that does not meet infants’ needs for food, sleep, and sensory experiences.

**Preventing Biting**: We work hard to prevent biting incidences from occurring, although we cannot guarantee there won’t be any biting. Infants bite for many reasons; it is not possible to predict or prevent every bite. However, what we do to help prevent the situation is to be professional, provide a supportive environment for the children, that is a consistent yet flexible schedule, provide a variety of sensory activities and materials, and interact with children gently and empathetically, while observing and following procedures we have in place.

**What we do when Infants do Bite**: The response that helps a child stop biting and keeps other children safe is different depending on each child’s need, temperament, and reason for biting. To determine the best response in a given situation, all staff closely observe children to find out why biting may be occurring. However, whatever the reason for the bite may be, the staff’s immediate response to the children is the same each time, acting quickly and directly. Whether it’s the first time or the seventh time someone bites another child. We appropriately help the children by putting our immediate empathy response to the child who was bitten and let them know they are safe and we will help them. We help the bitee express his/her emotions and responses by telling the biter to say, “Stop!” We then turn to the child who has bit and state strongly that it is never okay to bite people. We include descriptive words and comments such as, “You bit him with your teeth. He doesn’t like that [or “It hurts, see his tears”]. It’s not okay to bite people. “Or, if it was observed, what led to the incident, such as frustration because a toy was taken away, we may help that child with stating emotions such as, “You were so mad when the truck was taken out of your hands by [the other child] and you bit him. Biting hurts people. I’ll help you when your truck is taken away from you. But there is no biting.” We also help the biter by saying, “You tell [the other child], “No!” “Stop” or “Mine (My turn!), but there is no biting.” It is important that a child feels strong and able to express and assert self with language. We then help the biter to be redirected to another space or activity.
When approaching a biting incidence, we tie our verbal response to an action response. By this, we mean that while we want to send the message that biting is not the right thing to do, we also direct infants to what we do want them to do by helping them with appropriate behaviors and reactions similar to the ones states above.

**What we don’t do and why:**

- Apologies: the thought behind saying “I’m sorry” is to teach children to be accountable for their behavior by apologizing. While this may be a good motive, the practice is not a good fit for infants or for biting. When older infants are reminded or forced to say, “I’m sorry” in situations in which their behavior was inappropriate, they can readily learn to utter the words. They can even learn the correct contrite tone of voice. During the development stages of infants, they are still learning what it looks and feels like to be empathetic towards other people. Saying “I’m sorry” is not understandable at this developmental level. Being forced to say this over and over again, over time, children learn that it’s all right to hurt other people, as long as they say, “I’m sorry” afterward. It’s also the very opposite of genuinely taking responsibility for their own behavior.

- Time-Out: not being allowed to participate in an activity may make sense to adults as a punishment, and it might even serve to eliminate an older child’s misbehavior. A time out makes sense to adults because the adult can connect the punishment to the behavior. Infants, however, do not experience a time-out in the same way because they don’t make that connection. The developmental psychologist, Jean Piaget, reminds us, the way young children think and reason is different from the way older children and adults think and reason.

- Saying, “How would you like it...?”: Variations of this technique to Infants include, “Would you want someone to bite you?“ and “Do you like it when people bite (hurt) you?” Even if Infants were to agree and say “No,” because they certainly wouldn’t want it done to them, adults may take the next logical step of saying, “Well, then, if you don’t want to be bitten, that child doesn’t want to be bit either.” This makes sense to adults because it is a logical step, but that is exactly why it doesn’t work with Infants. They don’t think logically, therefore, they cannot make that logical step. Logic is one of the characteristics of the thinking of older children and adults, not young children.

- Lecturing or Going on a Tirade: Responding to biting by telling the child at length what she did wrong and why (a lecture) or by telling her over and over again, with a lot of emotion, not to do something (a tirade), are both ineffective approaches to stopping biting behavior. Lectures are ineffective because they are usually too long and not given in infant-
friendly language. The child needs to hear briefly and clearly what happened, what was wrong, and what to do next. Tirades are ineffective because the adult’s voice and body language frighten or surprise the children, and the message usually gets lost.

Policy Components: Because we want the biting to stop as quickly as possible, we don’t use techniques that alarm, hurt, or frighten children. When we have episodes of ongoing biting, we develop a plan of specific strategies, techniques, and timelines to address it. This plan is shared with parents who are involved (to the child who bit). When a child has bitten another child, we address both sets of parents, explaining the situation. However, please note, that our information shared concerning biting is kept confidential. This applies to the name of the child who bit and the child who was bitten. This is the law that we abide by.

WHEN INFANTS EXPERIENCE HURTFUL BEHAVIORS

It is UMCDC’s goal to provide a safe and healthy environment for all children. We are aware, however, that young children commonly engage in hurtful behaviors as part of their developmental experience. UMCDC considers the following physical behaviors to be NOT ACCEPTABLE: hitting with hands, hitting with objects, scratching, pushing, pinching, hair pulling, throwing sand, kicking, biting, etc. We are concerned about these behaviors and take them seriously.

SPECIFIC TO THE IMMEDIATE SITUATION OF A HURTFUL BEHAVIOR, ALL FULL-TIME AND PART-TIME STAFF ARE INSTRUCTED TO:

1. Use a very firm voice to say, “STOP! THAT HURTS!”

2. If one child is still hurting another child, physically separate them to stop the hurtful behavior.

   NOTE: attention is focused on the child hurt, not the child who caused the hurtful behavior

3. Give any first aid that is needed, such as washing hurt area with soap and water, applying cold pack, etc.

4. To the child who caused the hurtful behavior, say “Use gentle touches like this (which the adult models) be gentle with your friends.”

5. Complete an accident report describing the situation surrounding the hurtful behavior, without naming the child who caused the injury. This report is given to the parents of the hurt child at pick up time. The name of the child causing the injury is placed on the yellow copy that is forwarded to the Director.
6. Teaching staff use their best judgment in determining when to contact parents of the hurt child. Parents may be encouraged to contact their health care provider, depending upon the injury.

7. Teaching staff use their best judgment in determining when, whether, and how to inform the parents of the child who caused the hurtful behavior. Parents may request early notification if there is a behavior causing them concern.

8. If a pattern of hurtful behaviors develops, documentation will be placed in the file of the child who caused the hurtful behavior. Parents of the child doing the hurtful behavior(s) will be contacted to work with the teaching staff to create and implement an intervention strategy.

Please note: data privacy prevents UMCDC from revealing any information specific to the children and families involved in a hurtful behavior.

POLICY REGARDING HURTFUL BEHAVIORS BETWEEN CHILDREN

It is UMCDC’s goal is to guide and provide a safe and healthy environment for all children. We are aware, however, that young children commonly engage in hurtful behaviors as part of their developmental experience. As parents and teachers, we will better understand our children if we consider the many reasons why one child may hurt another:

- Lack of language skills
- Anxiety/stress
- Overcrowding
- Curiosity
- Teething
- Lack of social interaction skills
- Frustration
- Tiredness/Fatigue
- Not feeling well
- Ear Infection
- Lack of impulse control
- Lack of motor control
- Anger
- Defending property or space
- Lowered coping ability
- Sensory needs
- Hunger
- Peer Interactions

UMCDC considers the following physical behaviors to be NOT ACCEPTABLE: hitting with hands, hitting with objects, scratching, pushing, pinching, hair pulling, throwing sand, kicking, biting, etc. We are concerned about these behaviors and take them seriously.
Hurtful behaviors, and the Center’s response, differ by age group and situation. In the event of a hurtful interaction between children, UMCDC staff intervene immediately with the children involved. Teaching staff use their best judgment in determining when and how to contact parents of the hurt child and the child who has caused the hurtful behavior. The situation is first evaluated by teaching staff and the Area Coordinator, and may also involve the Education Coordinator and/or the UMCDC Director, to identify the source of the behavior and take steps to eliminate it. In some cases, referral to an outside agency may be indicated. It is expected that parents cooperate with teaching and administrative staff when such a referral is indicated. Lack of such cooperation may result in termination of enrollment and childcare services. Please refer to the Parent Handbook for more details about this process.

Please note: data privacy prevents UMCDC from revealing any information specific to the children and families involved in a hurtful behavior situation.

**STRATEGIES**

Teaching staff reflects and analyses the behaviors and the children involved to see if there is a pattern. When teaching staff has reviewed that data, records, observation, for time, place, and circumstances of the hurtful behavior, they will implement strategies to address the behaviors. Examples:

a. Make changes to materials and the environment

b. Adapt how the children are divided for transitions, teacher-directed activities, and small groups and routines.

c. Change how transitions are completed

d. Use these situations as teachable moments to guide and teach/model appropriate responses

e. Depending upon the situation, staff may shadow the child who is causing the hurtful behavior, or in some cases, the child who is causing the hurtful behavior, or in some cases, the child who is hurt (to observe, interfere, use a mediator)

f. Redirect child to prevent frustrating and over-stimulating situations from occurring

g. Observe and evaluate how full-time staff and CCW’s interact with the child; reflect and change interactions and respond.