



Childcare and Diabetes: Additional Resources

1. ADA School and Day Care Position Statement
2. Commonly Asked Questions about Child Care and the ADA
3. Press Release on Pine Hills Settlement
4. Safe at School: Safety and Fairness for Children with Diabetes

Diabetes Care in the School and Day Care Setting

AMERICAN DIABETES ASSOCIATION

Diabetes is one of the most common chronic diseases of childhood (1). There are ~215,000 individuals <20 years of age with diabetes in the U.S. (2). The majority of these young people attend school and/or some type of day care and need knowledgeable staff to provide a safe school environment. Both parents and the health care team should work together to provide school systems and day care providers with the information necessary to allow children with diabetes to participate fully and safely in the school experience (3,4).

DIABETES AND THE LAW

—Federal laws that protect children with diabetes include Section 504 of the Rehabilitation Act of 1973 (5), the Individuals with Disabilities Education Act (originally the Education for All Handicapped Children Act of 1975) (6), and the Americans with Disabilities Act (7). Under these laws, diabetes has been considered to be a disability, and it is illegal for schools and/or day care centers to discriminate against children with disabilities. In addition, any school that receives federal funding or any facility considered open to the public must reasonably accommodate the special needs of children with diabetes. Indeed, federal law requires an individualized assessment of any child with diabetes. The required accommodations should be documented in a written plan developed under the applicable federal law such as a Section 504 Plan or Individualized Education Program (IEP). The needs of a student with diabetes should be provided for within the child’s usual school setting with as little disruption to the school’s and the child’s routine as possible and allowing

the child full participation in all school activities (8,9).

Despite these protections, children in the school and day care setting still face discrimination. For example, some day care centers may refuse admission to children with diabetes, and children in the classroom may not be provided the assistance necessary to monitor blood glucose and administer insulin and may be prohibited from eating needed snacks. The American Diabetes Association works to ensure the safe and fair treatment of children with diabetes in the school and day care setting (10–15) (www.diabetes.org/schooldiscrimination).

Diabetes care in schools

Appropriate diabetes care in the school and day care setting is necessary for the child’s immediate safety, long-term well-being, and optimal academic performance. The Diabetes Control and Complications Trial showed a significant link between blood glucose control and later development of diabetes complications, with improved glycemic control decreasing the risk of these complications (16,17). To achieve glycemic control, a child must check blood glucose frequently, monitor food intake, take medications, and engage in regular physical activity. Insulin is usually taken in multiple daily injections or through an infusion pump. Crucial to achieving glycemic control is an understanding of the effects of physical activity, nutrition therapy, and insulin on blood glucose levels.

To facilitate the appropriate care of the student with diabetes, the school nurse as well as other school and day care personnel must have an understanding of diabetes and must be trained in its management and in the treatment of diabetes emergencies (3,18,19,20,34,36).

Knowledgeable trained personnel are essential if the student is to avoid the immediate health risks of low blood glucose and to achieve the metabolic control required to decrease risks for later development of diabetes complications (3,20). Studies have shown that the majority of school personnel have an inadequate understanding of diabetes (21,22). Consequently, diabetes education must be targeted toward day care providers, teachers, and other school personnel who interact with the child, including school administrators, school nurses, coaches, health aides, bus drivers, secretaries, etc. (3,20). Current recommendations and up-to-date resources regarding appropriate care for children with diabetes in the school are universally available to all school personnel (3,23).

The purpose of this position statement is to provide recommendations for the management of children with diabetes in the school and day care setting.

GENERAL GUIDELINES FOR THE CARE OF THE CHILD IN THE SCHOOL AND DAY CARE SETTING

I. Diabetes Medical Management Plan

An individualized Diabetes Medical Management Plan (DMMP) should be developed by the student’s personal diabetes health care team with input from the parent/guardian. Inherent in this process are delineated responsibilities assumed by all parties, including the parent/guardian, the school personnel, and the student (3,24,25). These responsibilities are outlined in this position statement. In addition, the DMMP should be used as the basis for the development of written education plans such as the Section 504 Plan or the IEP. The DMMP should address the specific needs of the child and provide specific instructions for each of the following:

Originally approved 1998. Revised 2008.

DOI: 10.2337/dc13-S075

© 2013 by the American Diabetes Association. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. See <http://creativecommons.org/licenses/by-nc-nd/3.0/> for details.

1. Blood glucose monitoring, including the frequency and circumstances requiring blood glucose checks, and use of continuous glucose monitoring if utilized.
2. Insulin administration (if necessary), including doses/injection times prescribed for specific blood glucose values and for carbohydrate intake, the storage of insulin, and, when appropriate, physician authorization of parent/guardian adjustments to insulin dosage.
3. Meals and snacks, including food content, amounts, and timing.
4. Symptoms and treatment of hypoglycemia (low blood glucose), including the administration of glucagon if recommended by the student's treating physician.
5. Symptoms and treatment of hyperglycemia (high blood glucose).
6. Checking for ketones and appropriate actions to take for abnormal ketone levels, if requested by the student's health care provider.
7. Participation in physical activity.
8. Emergency evacuation/school lockdown instructions.

A sample DMMP (<http://professional.diabetes.org/DMMP>) may be accessed online and customized for each individual student. For detailed information on the symptoms and treatment of hypoglycemia and hyperglycemia, refer to *Medical Management of Type 1 Diabetes* (26). A brief description of diabetes targeted to school and day care personnel is included in the APPENDIX; it may be helpful to include this information as an introduction to the DMMP.

II. Responsibilities of the various care providers

A. The parent/guardian should provide the school or day care provider with the following:

1. All materials, equipment, insulin, and other medication necessary for diabetes care tasks, including blood glucose monitoring, insulin administration (if needed), and urine or blood ketone monitoring. The parent/guardian is responsible for the maintenance of the blood glucose monitoring equipment (i.e., cleaning and performing controlled testing per the manufacturer's instructions) and must provide materials necessary

to ensure proper disposal of materials. A separate logbook should be kept at school with the diabetes supplies for the staff or student to record blood glucose and ketone results; blood glucose values should be transmitted to the parent/guardian for review as often as requested. Some students maintain a record of blood glucose results in meter memory rather than recording in a logbook, especially if the same meter is used at home and at school.

2. The DMMP completed and signed by the student's personal diabetes health care team.
3. Supplies to treat hypoglycemia, including a source of glucose and a glucagon emergency kit, if indicated in the DMMP.
4. Information about diabetes and the performance of diabetes-related tasks.
5. Emergency phone numbers for the parent/guardian and the diabetes health care team so that the school can contact these individuals with diabetes-related questions and/or during emergencies.
6. Information about the student's meal/snack schedule. The parent should work with the school during the beginning of the school year or before the student returns to school after diagnosis to coordinate this schedule with that of the other students as closely as possible. For young children, instructions should be given for when food is provided during school parties and other activities.
7. In most locations, and increasingly, a signed release of confidentiality from the legal guardian will be required so that the health care team can communicate with the school. Copies should be retained both at the school and in the health care professionals' offices.

B. The school or day care provider should provide the following:

1. Opportunities for the appropriate level of ongoing training and diabetes education for the school nurse.
2. Training for school personnel as follows: level 1 training for all school staff members, which includes a basic overview of diabetes, typical needs of a student with diabetes, recognition of hypoglycemia and hyperglycemia, and who to contact for

help; level 2 training for school staff members who have responsibility for a student or students with diabetes, which includes all content from level 1 plus recognition and treatment of hypoglycemia and hyperglycemia and required accommodations for those students; and level 3 training for a small group of school staff members who will perform student-specific routine and emergency care tasks such as blood glucose monitoring, insulin administration, and glucagon administration when a school nurse is not available to perform these tasks and which will include level 1 and 2 training as well.

3. Immediate accessibility to the treatment of hypoglycemia by a knowledgeable adult. The student should remain supervised until appropriate treatment has been administered, and the treatment should be available as close to where the student is as possible.
4. Accessibility to scheduled insulin at times set out in the student's DMMP as well as immediate accessibility to treatment for hyperglycemia including insulin administration as set out by the student's DMMP.
5. A location in the school that provides privacy during blood glucose monitoring and insulin administration, if desired by the student and family, or permission for the student to check his or her blood glucose level and take appropriate action to treat hypoglycemia in the classroom or anywhere the student is in conjunction with a school activity, if indicated in the student's DMMP.
6. School nurse and back-up trained school personnel who can check blood glucose and ketones and administer insulin, glucagon, and other medications as indicated by the student's DMMP.
7. School nurse and back-up trained school personnel responsible for the student who will know the schedule of the student's meals and snacks and work with the parent/guardian to coordinate this schedule with that of the other students as closely as possible. This individual will also notify the parent/guardian in advance of any expected changes in the school schedule that affect the student's meal times or exercise routine and will remind young children of snack times.

Table 1—Resources for teachers, child care providers, parents, and health professionals

- Helping the Student with Diabetes Succeed: A Guide for School Personnel*. National Diabetes Education Program, 2010. Available at <http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=97#main>
- Diabetes Care Tasks at School: What Key Personnel Need to Know*. Alexandria, VA, American Diabetes Association, 2008. Available at <http://shopdiabetes.org/58-diabetes-care-tasks-at-school-what-key-personnel-need-to-know-2010-edition.aspx>
- Your School & Your Rights: Protecting Children with Diabetes Against Discrimination in Schools and Day Care Centers*. Alexandria, VA, American Diabetes Association, 2005 (brochure). Available at <http://www.diabetes.org/assets/pdfs/schools/your-school-your-right-2010.pdf>*
- Children with Diabetes: Information for School and Child Care Providers*. Alexandria, VA, American Diabetes Association, 2004 (brochure). Available at <http://shopdiabetes.org/42-children-with-diabetes-information-for-school-and-child-care-providers.aspx>*
- ADA's *Safe at School* campaign and information on how to keep children with diabetes safe at school. Call 1-800-DIABETES and go to <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/>
- American Diabetes Association: *Complete Guide to Diabetes*. Alexandria, VA, American Diabetes Association, 2011. Available at <http://www.shopdiabetes.org/551-American-Diabetes-Association-Complete-Guide-to-Diabetes-5th-Edition.aspx>
- American Diabetes Association: *Guide to Raising a Child With Diabetes, 3rd ed.* Alexandria, VA, American Diabetes Association, 2011. Available at <http://www.shopdiabetes.org/548-ADA-Guide-to-Raising-a-Child-with-Diabetes-3rd-Edition.aspx>
- Clarke W: Advocating for the child with diabetes. *Diabetes Spectrum* 12:230–236, 1999
- School Discrimination Resources*. Alexandria, VA, American Diabetes Association, 2006. Available at <http://www.diabetes.org/living-with-diabetes/know-your-rights/discrimination/school-discrimination/>*
- Every Day Wisdom: A Kit for Kids with Diabetes (and their parents)*. Alexandria, VA, American Diabetes Association, 2000. Available at http://www.diabetes.org/living-with-diabetes/parents-and-kids/everyday-wisdom-kit-nov-dec-2012.html?loc=righttrail1_wisdomkit_evergreen
- ADA's *Planet D*, online information for children and youth with diabetes. Available at <http://www.diabetes.org/living-with-diabetes/parents-and-kids/planet-d/>

*Available in the American Diabetes Association's Education Discrimination Packet by calling 1-800-DIABETES.

8. Permission for self-sufficient and capable students to carry equipment, supplies, medication, and snacks; to perform diabetes management tasks; and to have cell phone access to reach parent/guardian and health care provider.
 9. Permission for the student to see the school nurse and other trained school personnel upon request.
 10. Permission for the student to eat a snack anywhere, including the classroom or the school bus, if necessary to prevent or treat hypoglycemia.
 11. Permission to miss school without consequences for illness and required medical appointments to monitor the student's diabetes management. This should be an excused absence with a doctor's note, if required by usual school policy.
 12. Permission for the student to use the restroom and have access to fluids (i.e., water) as necessary.
 13. An appropriate location for insulin and/or glucagon storage, if necessary.
 14. A plan for the disposal of sharps based upon an agreement with the student's family, local ordinances, and Universal Precaution Standards.
 15. Information on serving size and caloric, carbohydrate, and fat content of foods served in the school (27).
- The school nurse should be the key coordinator and provider of care and should coordinate the training of an adequate number of school personnel as specified above and ensure that if the school nurse is not present at least one adult is present who is trained to perform these procedures in a timely manner while the student is at school, on field trips, participating in school-sponsored extracurricular activities, and on transportation provided by the school or day care facility. This is needed in order to enable full participation in school activities (3,9,20,28,33,35).
- It is the school's responsibility to provide appropriate training of an adequate

number of school staff on diabetes-related tasks and in the treatment of diabetes emergencies. This training should be provided by the school nurse or another qualified health care professional with expertise in diabetes. Members of the student's diabetes health care team should provide school personnel and parents/guardians with educational materials from the American Diabetes Association and other sources targeted to school personnel and/or parents. Table 1 includes a listing of appropriate resources.

III. Expectations of the student in diabetes care

Children and youth should be allowed to provide their own diabetes care at school to the extent that is appropriate based on the student's development and his or her experience with diabetes. The extent of the student's ability to participate in diabetes care should be agreed upon by the school personnel, the parent/guardian, and the health care team, as necessary. The ages at which children are able to perform self-care tasks are variable and depend on the individual, and a child's capabilities and willingness to provide self-care should be respected (18).

1. *Toddlers and preschool-aged children*: unable to perform diabetes tasks independently and will need an adult to provide all aspects of diabetes care. Many of these younger children will have difficulty in recognizing hypoglycemia, so it is important that school personnel are able to recognize and provide prompt treatment. However, children in this age range can usually determine which finger to prick, can choose an injection site, and are generally cooperative.
2. *Elementary school-aged children*: depending on the length of diagnosis and level of maturity, may be able to perform their own blood glucose checks, but usually will require supervision. Older elementary school-aged children are generally beginning to self-administer insulin with supervision and understand the effect of insulin, physical activity, and nutrition on blood glucose levels. Unless the child has hypoglycemic unawareness, he or she should usually be able to let an adult know when experiencing hypoglycemia.
3. *Middle school- and high school-aged children*: usually able to provide self-care depending on the length of

diagnosis and level of maturity but will always need help when experiencing severe hypoglycemia. Independence in older children should be encouraged to enable the child to make his or her decisions about his or her own care.

Students' competence and capability for performing diabetes-related tasks are set out in the DMMP and then adapted to the school setting by the school health team and the parent/guardian. At all ages, individuals with diabetes may require help to perform a blood glucose check when the blood glucose is low. In addition, many individuals require a reminder to eat or drink during hypoglycemia and should not be left unsupervised until such treatment has taken place and the blood glucose value has returned to the normal range. Ultimately, each person with diabetes becomes responsible for all aspects of routine care, and it is important for school personnel to facilitate a student in reaching this goal. However, regardless of a student's ability to provide self-care, help will always be needed in the event of a diabetes emergency.

MONITORING BLOOD GLUCOSE IN THE CLASSROOM

—It is best for a student with diabetes to monitor blood glucose levels and respond to the results as quickly and conveniently as possible. This is important to avoid medical problems being worsened by a delay in monitoring and treatment and to minimize educational problems caused by missing instruction in the classroom. Accordingly, as stated earlier, a student should be permitted to monitor his or her blood glucose level and take appropriate action to treat hypoglycemia and hyperglycemia in the classroom or anywhere the student is in conjunction with a school activity, if preferred by the student and indicated in the student's DMMP (3,24). However, some students desire privacy for blood glucose monitoring and other diabetes care tasks, and this preference should also be accommodated.

In summary, with proper planning and the education and training of school personnel, children and youth with diabetes can fully participate in the school experience. To this end, the family, the health care team, and the school should work together to ensure a safe learning environment.

APPENDIX

Background information on diabetes for school personnel

Diabetes is a serious, chronic disease that impairs the body's ability to use food. Insulin, a hormone produced by the pancreas, helps the body convert food into energy. In people with diabetes, either the pancreas does not make insulin or the body cannot use insulin properly. Without insulin, the body's main energy source—glucose—cannot be used as fuel. Rather, glucose builds up in the blood. Over many years, high blood glucose levels can cause damage to the eyes, kidneys, nerves, heart, and blood vessels.

The majority of school-aged youth with diabetes have type 1 diabetes. People with type 1 diabetes do not produce insulin and must receive insulin through either injections or an insulin pump. Insulin taken in this manner does not cure diabetes and may cause the student's blood glucose level to become dangerously low. Type 2 diabetes, the most common form of the disease, typically afflicting obese adults, has been shown to be increasing in youth. This may be due to the increase in obesity and decrease in physical activity in young people. Students with type 2 diabetes may be able to control their disease through diet and exercise alone or may require oral medications and/or insulin injections. All people with type 1 and type 2 diabetes must carefully balance food, medications, and activity level to keep blood glucose levels as close to normal as possible.

Low blood glucose (hypoglycemia) is the most common immediate health problem for students with diabetes. It occurs when the body gets too much insulin, too little food, a delayed meal, or more than the usual amount of exercise. Symptoms of mild to moderate hypoglycemia include tremors, sweating, lightheadedness, irritability, confusion, and drowsiness. In younger children other symptoms may include inattention, falling asleep at inappropriate times, unexplained behavior, and temper tantrums. A student with this degree of hypoglycemia will need to ingest carbohydrates promptly and may require assistance. Severe hypoglycemia, which is rare, may lead to unconsciousness and convulsions and can be life-threatening if not treated promptly with glucagon as per the student's DMMP (18,24,29,30,31).

High blood glucose (hyperglycemia) occurs when the body gets too little insulin, too much food, or too little exercise; it may also be caused by stress or an illness such as a cold. The most common symptoms of hyperglycemia are thirst, frequent urination, and blurry vision. If untreated over a period of days, hyperglycemia and insufficient insulin can lead to a serious condition called diabetic ketoacidosis (DKA), which is characterized by nausea, vomiting, and a high level of ketones in the blood and urine. For students using insulin infusion pumps, lack of insulin supply may lead to DKA more rapidly. DKA can be life-threatening and thus requires immediate medical attention (32).

Acknowledgments—The American Diabetes Association thanks the members of the Health Care Professional Volunteer Writing Group for this updated statement: William Clarke, MD; Larry C. Deeb, MD; Paula Jameson, MSN, ARNP, CDE; Francine Kaufman, MD; Georgeanna Klingensmith, MD; Desmond Schatz, MD; Janet H. Silverstein, MD; and Linda M. Siminerio, RN, PhD, CDE.

References

1. American Diabetes Association: *American Diabetes Association Complete Guide to Diabetes*. 5th ed. Alexandria, VA, American Diabetes Association, 2011
2. Centers for Disease Control and Prevention: *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the United States, 2011*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011
3. National Institutes of Health: *Helping the Student with Diabetes Succeed: A Guide for School Personnel*. Bethesda, MD, National Diabetes Education Program (NIH publication no. 10-5217, revised September 2010)
4. Nabors L, Troillett A, Nash T, Masiulis B: School nurse perceptions of barriers and supports for children with diabetes. *J Sch Health* 75: 119–124, 2005
5. 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, implementing regulations at 35 CFR Part 104
6. Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., implementing regulations at 34 CFR Part 300
7. Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. 12134 et seq., implementing regulations at 28 CFR Part 35
8. Rapp J: Students with diabetes in schools. In *Inquiry & Analysis*. Alexandria, VA, National School Boards Association Council of School Attorneys, June 2005

9. Arent S, Kaufman F: Federal laws and diabetes management at school. *School Nurse News*, November 2004
10. *Jesi Stuthard and ADA v. Kindercare Learning Centers, Inc.* Case no. C2-96-0185 (USCD South Ohio 8/96)
11. *Calvin Davis and ADA v. LaPetite Academy, Inc.* Case no. CIV97-0083-PHX-SMM (USCD Arizona 1997)
12. Agreement, Loudoun County Public Schools (VA) and the Office for Civil Rights, United States Department of Education (Complaint nos. 11-99-1003, 11-99-1064, 11-99-1069, 1999)
13. *Henderson County (NC) Pub. Schls.*, Complaint no. 11-00-1008, 34 IDLER 43 (OCR 2000)
14. Rapp J, Arent S, Dimmick B, Jackson C: *Legal Rights of Students with Diabetes*. 2nd ed. Alexandria, VA, American Diabetes Association, October 2005, updated October 2009. Available from <http://www.diabetes.org/living-with-diabetes/know-your-rights/for-lawyers/education-materials-for-lawyers/legal-rights-of-students-with-diabetes.html>
15. Greene MA: Diabetes legal advocacy comes of age. *Diabetes Spectr* 19: 171–179, 2006
16. Diabetes Control and Complications Trial Research Group: Effect of intensive diabetes treatment on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 329: 977–986, 1993
17. Diabetes Control and Complications Trial Research Group: Effect of intensive diabetes treatment on the development and progression of long-term complications in adolescents with insulin-dependent diabetes mellitus. *J Pediatr* 125: 177–188, 1994
18. American Diabetes Association: Care of children and adolescents with type 1 diabetes (Position Statement). *Diabetes Care* 28: 186–212, 2005
19. Barrett JC, Goodwin DK, Kendrick O: Nursing, food service, and the child with diabetes. *J Sch Nurs* 18: 150–156, 2002
20. Jameson P: Developing diabetes training programs for school personnel. *School Nurse News*, September 2004
21. Wysocki T, Meinhold P, Cox DJ, Clarke WL: Survey of diabetes professionals regarding developmental charges in diabetes self-care. *Diabetes Care* 13: 65–68, 1990
22. Lindsey R, Jarrett L, Hillman K: Elementary schoolteachers' understanding of diabetes. *Diabetes Educ* 13: 312–314, 1987
23. American Diabetes Association: *Diabetes Care Tasks at School: What Key Personnel Need to Know*. Alexandria, VA, American Diabetes Association, 2008. Available from <http://www.diabetes.org/assets/pdfs/schools/forward2008.pdf>
24. Jameson P: Helping students with diabetes thrive in school. In *On the Cutting Edge, American Dietetic Association's Diabetes Care and Education Practice Group Newsletter*. Summer 2006, p. 26–29
25. Owen S: Pediatric pumps—barriers and breakthroughs. *Pediatric Pumps* 32 (Suppl. 1), January/February 2006
26. American Diabetes Association: *Medical Management of Type 1 Diabetes*. 6th ed. Kaufman F, Ed. Alexandria, VA, American Diabetes Association, 2012
27. *Accommodating Children with Special Dietary Needs in the School Nutrition Program: Guidance for School Food Service Staff*. Washington, DC, U.S. Department of Agriculture Food and Nutrition Service, 2001
28. American Diabetes Association: Safe at School Campaign Statement of Principles endorsed by American Academy of Pediatrics, American Association of Clinical Endocrinologists, American Association of Diabetes Educators, American Diabetes Association, American Dietetic Association, Children with Diabetes, Disability Rights Education Defense Fund, Juvenile Diabetes Research Foundation, Lawson Wilkins Pediatric Endocrine Society, Pediatric Endocrine Nursing Society, Endocrine Society [article online]. Available from <http://www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/safe-at-school-statement-of.html>
29. Evert A: Managing hypoglycemia in the school setting. *School Nurse News*, November 2005
30. Bulsara MD, Holman CD, David EA, Jones TW: The impact of a decade of changing treatment on rates of severe hypoglycemia in a population-based cohort of children with type 1 diabetes. *Diabetes Care* 27: 2293–2298, 2004
31. Nabors L, Lehmkuhl H, Christos N, Andreone TF: Children with diabetes: perceptions of supports for self-management at school. *J Sch Health* 73: 216–221, 2003
32. Kaufman FR: Diabetes mellitus. *Pediatr Rev* 18: 383–392, 1997
33. Pediatric Endocrine Nursing Society: *Children With Diabetes at School*. September 2005. Available from the Pediatric Endocrinology Nursing Society, 7794 Grow Dr., Pensacola, FL 32514
34. Committee on School Health, American Academy of Pediatrics Policy Statement: Guidance for the administration of medication in school. *Pediatrics* 124: 1244–1251, 2009
35. Hellems MA, Clarke WL: Safe at school: a Virginia experience. *Diabetes Care* 30: 1396–1398, 2007
36. American Medical Association: Report 4 of the Council on Science and Public Health (A-08): *Ensuring the Best In-School Care for Children with Diabetes* [article online], June 2008. Available from <http://www.ama-assn.org/resources/doc/csaph/csaph4a08.pdf>

U.S. Department of Justice

Civil Rights Division

Disability Rights Section

COMMONLY ASKED QUESTIONS ABOUT CHILD CARE CENTERS AND THE AMERICANS WITH DISABILITIES ACT

Coverage

1. Q: Does the Americans with Disabilities Act -- or "ADA" -- apply to child care centers?

A: Yes. Privately-run child care centers -- like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks -- must comply with title III of the ADA. Child care services provided by government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

A child care center's employment practices are covered by other parts of the ADA and are not addressed here. For more information about the ADA and employment practices, please call the Equal Employment Opportunity Commission (see question 30).

2. Q: Which child care centers are covered by title III?

A: Almost all child care providers, regardless of size or number of employees, must comply with title III of the ADA. Even small, home-based centers that may not have to follow some State laws are covered by title III.

The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

Private child care centers that are operating on the premises of a religious organization, however, are generally **not** exempt from title III. Where such areas are leased by a child care program not controlled or operated by the religious organization, title III applies to the child care program but not the religious organization. For example, if a private child care program is operated out of a

church, pays rent to the church, and has no other connection to the church, the program has to comply with title III but the church does not.

General Information

3. Q: What are the basic requirements of title III?

A: The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity to participate in the child care center's programs and services. Specifically:

- Centers cannot exclude children with disabilities from their programs unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.
- Centers have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.
- Centers must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.
- Centers must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

4. Q: How do I decide whether a child with a disability belongs in my program?

A: Child care centers cannot just assume that a child's disabilities are too severe for the child to be integrated successfully into the center's child care program. The center must make an *individualized assessment* about whether it can meet the particular needs of the child without fundamentally altering its program. In making this assessment, the caregiver must not react to unfounded preconceptions or stereotypes about what children with disabilities can or cannot do, or how much assistance they may require. Instead, the caregiver should talk to the parents or guardians and any other professionals (such as educators or health care professionals) who work with the child in other contexts. Providers are often surprised at how simple it is to include children with disabilities in their mainstream programs.

Child care centers that are accepting new children are not required to accept children who would

pose a *direct threat* (see question 8) or whose presence or necessary care would *fundamentally alter* the nature of the child care program.

5. Q: My insurance company says it will raise our rates if we accept children with disabilities. Do I still have to admit them into my program?

A: Yes. Higher insurance rates are not a valid reason for excluding children with disabilities from a child care program. The extra cost should be treated as overhead and divided equally among all paying customers.

6. Q: Our center is full and we have a waiting list. Do we have to accept children with disabilities ahead of others?

A: No. Title III does not require providers to take children with disabilities out of turn.

7. Q: Our center specializes in "group child care." Can we reject a child just because she needs individualized attention?

A: No. Most children will need individualized attention occasionally. If a child who needs one-to-one attention due to a disability can be integrated without fundamentally altering a child care program, the child cannot be excluded solely because the child needs one-to-one care.

For instance, if a child with Down Syndrome and significant mental retardation applies for admission and needs one-to-one care to benefit from a child care program, and a personal assistant will be provided at no cost to the child care center (usually by the parents or through a government program), the child cannot be excluded from the program solely because of the need for one-to-one care. Any modifications necessary to integrate such a child must be made if they are reasonable and would not fundamentally alter the program. This is not to suggest that all children with Down Syndrome need one-to-one care or must be accompanied by a personal assistant in order to be successfully integrated into a mainstream child care program. As in other cases, an *individualized assessment* is required. But the ADA generally does not require centers to hire additional staff or provide constant one-to-one supervision of a particular child with a disability.

8. Q: What about children whose presence is dangerous to others? Do we have to take them, too?

A: No. Children who pose a *direct threat* -- a substantial risk of serious harm to the health and safety of others -- do not have to be admitted into a program. The determination that a child poses a direct threat may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an *individualized assessment* that considers the particular activity and the actual abilities and disabilities of the individual.

In order to find out whether a child has a medical condition that poses a significant health threat

to others, child care providers may ask all applicants whether a child has any diseases that are communicable through the types of incidental contact expected to occur in child care settings. Providers may also inquire about specific conditions, such as active infectious tuberculosis, that in fact pose a direct threat.

9. Q: One of the children in my center hits and bites other children. His parents are now saying that I can't expel him because his bad behavior is due to a disability. What can I do?

A: The first thing the provider should do is try to work with the parents to see if there are reasonable ways of curbing the child's bad behavior. He may need extra naps, "time out," or changes in his diet or medication. If reasonable efforts have been made and the child continues to bite and hit children or staff, he may be expelled from the program even if he has a disability. The ADA does not require providers to take any action that would pose a *direct threat* -- a substantial risk of serious harm -- to the health or safety of others. Centers should not make assumptions, however, about how a child with a disability is likely to behave based on their past experiences with other children with disabilities. Each situation must be considered individually.

10. Q: One of the children in my center has parents who are deaf. I need to have a long discussion with them about their child's behavior and development. Do I have to provide a sign language interpreter for the meeting?

A: It depends. Child care centers must provide effective communication to the customers they serve, including parents and guardians with disabilities, unless doing so poses an undue burden. The person with a disability should be consulted about what types of auxiliary aids and services will be necessary in a particular context, given the complexity, duration, and nature of the communication, as well as the person's communication skills and history. Different types of *auxiliary aids and services* may be required for lengthy parent-teacher conferences than will normally be required for the types of incidental day-to-day communication that take place when children are dropped off or picked up from child care. As with other actions required by the ADA, providers cannot impose the cost of a qualified sign language interpreter or other auxiliary aid or service on the parent or guardian.

A particular auxiliary aid or service is not required by title III if it would pose an *undue burden*, that is, a significant difficulty or expense, relative to the center or parent company's resources.

11. Q: We have a "no pets" policy. Do I have to allow a child with a disability to bring a service animal, such as a seeing eye dog?

A: Yes. A service animal is **not** a pet. The ADA requires you to modify your "no pets" policy to allow the use of a service animal by a person with a disability. This does not mean that you must abandon your "no pets" policy altogether, but simply that you must make an exception to your general rule for service animals.

12. Q: If an older child has delayed speech or developmental disabilities, can we place that child in the infant or toddler room?

A: Generally, no. Under most circumstances, children with disabilities must be placed in their age-appropriate classroom, unless the parents or guardians agree otherwise.

13. Q: Can I charge the parents for special services provided to a child with a disability, provided that the charges are reasonable?

A: It depends. If the service is required by the ADA, you cannot impose a surcharge for it. It is only if you go beyond what is required by law that you can charge for those services. For instance, if a child requires complicated medical procedures that can only be done by licensed medical personnel, and the center does not normally have such personnel on staff, the center would not be required to provide the medical services under the ADA. If the center chooses to go beyond its legal obligation and provide the services, it may charge the parents or guardians accordingly. On the other hand, if a center is asked to do simple procedures that are required by the ADA -- such as finger-prick blood glucose tests for children with diabetes (see question 20) -- it cannot charge the parents extra for those services. To help offset the costs of actions or services that are required by the ADA, including but not limited to architectural barrier removal, providing sign language interpreters, or purchasing adaptive equipment, some tax credits and deductions may be available (see question 24).

Personal Services

14. Q: Our center has a policy that we will not give medication to any child. Can I refuse to give medication to a child with a disability?

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. While some state laws may differ, generally speaking, as long as reasonable care is used in following the doctors' and parents' or guardians' written instructions about administering medication, centers should not be held liable for any resulting problems. Providers, parents, and guardians are urged to consult professionals in their state whenever liability questions arise.

15. Q: We diaper young children, but we have a policy that we will not accept children more than three years of age who need diapering. Can we reject children older than three who need diapering because of a disability?

A: Generally, no. Centers that provide personal services such as diapering or toileting assistance for young children must reasonably modify their policies and provide diapering services for older children who need it due to a disability. Generally speaking, centers that diaper infants should

diaper older children with disabilities when they would not have to leave other children unattended to do so.

Centers must also provide diapering services to young children with disabilities who may need it more often than others their age.

Some children will need assistance in transferring to and from the toilet because of mobility or coordination problems. Centers should not consider this type of assistance to be a "personal service."

16. Q: We do not normally diaper children of any age who are not toilet trained. Do we still have to help older children who need diapering or toileting assistance due to a disability?

A: It depends. To determine when it is a reasonable modification to provide diapering for an older child who needs diapering because of a disability and a center does not normally provide diapering, the center should consider factors including, but not limited to, (1) whether other non-disabled children are young enough to need intermittent toileting assistance when, for instance, they have accidents; (2) whether providing toileting assistance or diapering on a regular basis would require a child care provider to leave other children unattended; and (3) whether the center would have to purchase diapering tables or other equipment.

If the program never provides toileting assistance to any child, however, then such a personal service would not be required for a child with a disability. Please keep in mind that even in these circumstances, the child could not be excluded from the program because he or she was not toilet trained if the center can make other arrangements, such as having a parent or personal assistant come and do the diapering.

Issues Regarding Specific Disabilities

17. Q: Can we exclude children with HIV or AIDS from our program to protect other children and employees?

A: No. Centers cannot exclude a child solely because he has HIV or AIDS. According to the vast weight of scientific authority, HIV/AIDS cannot be easily transmitted during the types of incidental contact that take place in child care centers. Children with HIV or AIDS generally can be safely integrated into all activities of a child care program. Universal precautions, such as wearing latex gloves, should be used whenever caregivers come into contact with children's blood or bodily fluids, such as when they are cleansing and bandaging playground wounds. This applies to the care of all children, whether or not they are known to have disabilities.

18. Q: Must we admit children with mental retardation and include them in all center activities?

A: Centers cannot generally exclude a child just because he or she has mental retardation. The center must take reasonable steps to integrate that child into every activity provided to others. If other children are included in group sings or on playground expeditions, children with disabilities should be included as well. Segregating children with disabilities is not acceptable under the ADA.

19. Q: What about children who have severe, sometimes life-threatening allergies to bee stings or certain foods? Do we have to take them?

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A center needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called "epinephrine" that will be provided in advance by the child's parents or guardians.

The Department of Justice's settlement agreement with La Petite Academy addresses this issue and others (see question 26).

20. Q: What about children with diabetes? Do we have to admit them to our program? If we do, do we have to test their blood sugar levels?

A: Generally, yes. Children with diabetes can usually be integrated into a child care program without fundamentally altering it, so they should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child's blood sugar -- or "blood glucose" -- levels before lunch and whenever the child appears to be having certain easy-to-recognize symptoms of a low blood sugar incident. While the process may seem uncomfortable or even frightening to those unfamiliar with it, monitoring a child's blood sugar is easy to do with minimal training and takes only a minute or two. Once the caregiver has the blood sugar level, he or she must take whatever simple actions have been recommended by the child's parents or guardians and doctor, such as giving the child some fruit juice if the child's blood sugar level is low. The child's parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

The Department of Justice's settlement agreements with KinderCare and La Petite Academy address this issue and others (see question 26).

21. Q: Do we have to help children take off and put on their leg braces and provide similar types of assistance to children with mobility impairments?

A: Generally, yes. Some children with mobility impairments may need assistance in taking off and putting on leg or foot braces during the child care day. As long as doing so would not be so time consuming that other children would have to be left unattended, or so complicated that it can only be done by licensed health care professionals, it would be a *reasonable modification* to provide such assistance.

The Department of Justice's settlement agreement with the Sunshine Child Center of Gillett, Wisconsin, addresses this issue and others (see question 26).

Making the Child Care Facility Accessible

22. Q: How do I make my child care center's building, playground, and parking lot accessible to people with disabilities?

A: Even if you do not have any disabled people in your program now, you have an ongoing obligation to remove barriers to access for people with disabilities. Existing privately-run child care centers must remove those architectural barriers that limit the participation of children with disabilities (or parents, guardians, or prospective customers with disabilities) if removing the barriers is *readily achievable*, that is, if the barrier removal can be easily accomplished and can be carried out without much difficulty or expense. Installing offset hinges to widen a door opening, installing grab bars in toilet stalls, or rearranging tables, chairs, and other furniture are all examples of barrier removal that might be undertaken to allow a child in a wheelchair to participate in a child care program. Centers run by government agencies must insure that their programs are accessible unless making changes imposes an undue burden; these changes will sometimes include changes to the facilities.

23. Q: We are going to build a new facility. What architectural standards do we have to follow to make sure that our facility is accessible to people with disabilities?

A: Newly constructed privately-run child care centers -- those designed and constructed for first occupancy after January 26, 1993 -- must be readily accessible to and usable by individuals with disabilities. This means that they must be built in strict compliance with the ADA Standards for Accessible Design. New centers run by government agencies must meet either the ADA Standards or the Uniform Federal Accessibility Standards.

Tax Provisions

24. Q: Are there tax credits or deductions available to help offset the costs associated with complying with the ADA?

A: To assist businesses in complying with the ADA, Section 44 of the IRS Code allows a tax credit for small businesses and Section 190 of the IRS Code allows a tax deduction for all businesses.

The tax credit is available to businesses that have total revenues of \$1,000,000 or less in the previous tax year or 30 or fewer full-time employees. This credit can cover 50% of the eligible access expenditures in a year up to \$10,250 (maximum credit of \$5,000). The tax credit can be used to offset the cost of complying with the ADA, including, but not limited to, undertaking barrier removal and alterations to improve accessibility; provide sign language interpreters; and for purchasing certain adaptive equipment.

The tax deduction is available to all businesses with a maximum deduction of \$15,000 per year. The tax deduction can be claimed for expenses incurred in barrier removal and alterations.

To order documents about the tax credit and tax deduction provisions, contact the Department of Justice's ADA Information Line (see question 30).

The Department of Justice's Enforcement Efforts

25. Q: What is the Department of Justice's enforcement philosophy regarding title III of the ADA?

A: Whenever the Department receives a complaint or is asked to join an on-going lawsuit, it first investigates the allegations and tries to resolve them through informal or formal settlements. The vast majority of complaints are resolved voluntarily through these efforts. If voluntary compliance is not forthcoming, the Department may have to litigate and seek injunctive relief, damages for aggrieved individuals, and civil penalties.

26. Q: Has the United States entered into any settlement agreements involving child care centers?

A: The Department has resolved three matters through formal settlement agreements with the Sunshine Child Center, KinderCare Learning Centers, and La Petite Academy.

- In the first agreement, Sunshine Child Center in Gillett, Wisconsin, agreed to: (1) provide diapering services to children who, because of their disabilities, require diapering more often or at a later age than nondisabled children; (2) put on and remove the complainant's leg braces as necessary; (3) ensure that the complainant is not unnecessarily segregated from her age-appropriate classroom; (4) engage in readily achievable barrier removal to its existing facility; and (5) design and construct its new facility (planned independently of the Department's investigation) in a manner that is accessible to persons with disabilities.
- In 1996, the Department of Justice entered into a settlement agreement with KinderCare Learning Centers -- the largest chain of child care centers in the country -- under which

KinderCare agreed to provide appropriate care for children with diabetes, including providing finger-prick blood glucose tests. In 1997, La Petite Academy -- the second-largest chain -- agreed to follow the same procedures.

- In its 1997 settlement agreement with the Department of Justice, La Petite Academy also agreed to keep epinephrine on hand to administer to children who have severe and possibly life-threatening allergy attacks due to exposure to certain foods or bee stings and to make changes to some of its programs so that children with cerebral palsy can participate.

The settlement agreements and their attachments, including a waiver of liability form and parent and physician authorization form, can be obtained by calling the Department's ADA Information Line or through the Internet (see question 30). Child care centers and parents or guardians should consult a lawyer in their home state to determine whether any changes need to be made before the documents are used.

27. Q: Has the Department of Justice ever sued a child care center for ADA violations?

A: Yes. On June 30, 1997, the United States filed lawsuits against three child care providers for refusing to enroll a four-year-old child because he has HIV. See **United States v. Happy Time Day Care Center**, (W.D. Wisc.); **United States v. Kiddie Ranch**, (W.D. Wisc.); and **United States v. ABC Nursery, Inc.** (W.D. Wisc.).

28. Q: Does the United States ever participate in lawsuits brought by private citizens?

A: Yes. The Department sometimes participates in private suits either by intervention or as *amicus curiae* -- "friend of the court." One suit in which the United States participated was brought by a disability rights group against KinderCare Learning Centers. The United States supported the plaintiff's position that KinderCare had to make its program accessible to a boy with multiple disabilities including mental retardation. The litigation resulted in KinderCare's agreement to develop a model policy to allow the child to attend one of its centers with a state-funded personal assistant.

Additional Resources

29. Q: Are there any reference books or video tapes that might help me further understand the obligations of child care providers under title III?

A: Through a grant from the Department of Justice, The Arc published *All Kids Count: Child Care and the ADA*, which addresses the ADA's obligations of child care providers. Copies are available for a nominal fee by calling The Arc's National Headquarters in Arlington, Texas:

800-433-5255 (voice)

800-855-1155 (TDD)

Under a grant provided by the Department of Justice, Eastern Washington University (EWU) produced eight 5-7 minute videotapes and eight accompanying booklets on the ADA and child care providers. The videos cover different ADA issues related to child care and can be purchased as a set or individually by contacting the EWU at:

509-623-4246 (voice)

TDD: use relay service

30. Q: I still have some general questions about the ADA. Where can I get more information?

A: The Department of Justice operates an ADA Information Line. Information Specialists are available to answer general and technical questions during business hours on the weekdays. The Information Line also provides 24-hour automated service for ordering ADA materials and an automated fax back system that delivers technical assistance materials to fax machines or modems.

800-514-0301 (voice)

800-514-0383 (TDD)

The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page.

www.usdoj.gov/crt/ada/adahom1.htm

The Department of Justice also operates an ADA Electronic Bulletin Board, on which a wide variety of information and documents are available.

202-514-6193 (by computer modem)

There are ten regional Disability and Business Technical Assistance Centers, or DBTAC's, that are funded by the Department of Education to provide technical assistance under the ADA. One

toll-free number connects to the center in your region.

800-949-4232 (voice & TDD)

The Access Board offers technical assistance on the ADA Accessibility Guidelines.

800-872-2253 (voice)

800-993-2822 (TDD)

Electronic Bulletin Board

202-272-5448

The Equal Employment Opportunity Commission, or EEOC, offers technical assistance on the ADA provisions for employment which apply to businesses with 15 or more employees.

Employment questions

800-669-4000 (voice)

800-669-6820 (TDD)

Employment documents

800-669-3362 (voice)

800-800-3302 (TDD)

If you have further questions about child care centers or other requirements of the ADA, you may call the U.S. Department of Justice's toll-free ADA Information Line at: 800-514-0301 (voice) or 800-514-0383 (TDD).

Note: Reproduction of this document is encouraged.

10/97



Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Monday, October 19, 2009

Justice Department Reaches ADA Settlement with Fort Wayne, Indiana, Day Care Center Regarding Children with Diabetes

WASHINGTON – Pine Hills Kiddie Garden of Fort Wayne, Ind., will take necessary steps to ensure that a child's diabetes care is integrated into the usual routine of its day care center and programs as part of a settlement to resolve allegations that it discriminated on the basis of disability, the Justice Department announced today.

The settlement resolves a complaint filed by a parent of a six-year-old girl with Type I diabetes, alleging that Pine Hills refused in 2007 to permit the girl to participate in field trips as part of the summer program unless she was accompanied by a parent or a medically trained person hired by the parent. The complaint was filed under title III of the Americans with Disabilities Act (ADA).

"Parents of children with Type I diabetes deserve the comfort of knowing that their children will not be subjected to discrimination because of their illness. A day care center is required to evaluate and make reasonable modifications for children with diabetes," said Thomas E. Perez, Assistant Attorney General for the Civil Rights Division. "We commend Pine Hills Kiddie Garden for working cooperatively with the Department on today's settlement, which will ensure equal opportunity for children with diabetes in the day care center."

Under the settlement, Pine Hills agrees to provide all children with diabetes with an equal opportunity to attend the center and to participate in all programs, services or activities. It will evaluate the application of each child with diabetes applying to attend the center, on a case by case basis, and will make reasonable modifications to permit children with diabetes to attend the center. Modifications include, but are not limited to, supervising and monitoring of children with diabetes while using blood tests, insulin pumps, syringes or other diabetes related equipment or while consuming of food while participating in a program. Pine Hills also agrees to pay \$10,000 in compensatory damages and \$10,000 in civil penalties.

Under the settlement, Pine Hills submits that it has made and continues to make a practice of many of the policies outlined in the agreement and that it incorporates additional policies suggested by the Justice Department.

People interested in finding out more about the ADA or the agreement can call the Justice Department's toll-free ADA Information Line at (800) 514-0301 or (800) 514-0383 (TTY) or access its ADA Web site at www.ada.gov.

Fact Sheet: The Rights of Children with Diabetes in Childcare

Children with diabetes need childcare like any other children. But it can sometimes be confusing to know how to get them the best possible care. This is especially true when a childcare center has not taken care of a child with diabetes before. This fact sheet can help parents and guardians make sure their children are safe and healthy no matter where they go for childcare. This fact sheet applies to many different places, including Head Start, afterschool childcare programs, day camps, recreational programs, and sleep-away camps.

What Care Should Be Provided?

1. What diabetes care might my childcare center need to give my child?

You should make sure that you know how your child will get the following diabetes care:

- a. **Blood glucose monitoring.** If blood glucose (sugar) is out of target range, your child can be at risk for both short-term emergencies and long-term complications.
- b. **Carbohydrate counting.** In order to know how much insulin your child should get, it is necessary to know how many carbohydrates your child has eaten.
- c. **Insulin administration.** This can be either through injection by a syringe or pen, or through an insulin pump. In the United States, the standard of care for children with type 1 diabetes is to give them many daily injections of insulin, or place them on an insulin pump (which provides a continuous, small dose of insulin).
- d. **Glucagon administration.** If your child experiences very low blood glucose (hypoglycemia), glucagon can save his or her life. Like an EpiPen® (epinephrine) for allergies or an inhaler for asthma, glucagon is a rescue medicine that can save lives if used right away.

2. What else should my childcare center do to make sure that my child is safe and treated fairly?

- a. All staff members who regularly work with your child should know the warning signs of low and high blood glucose (hypoglycemia and hyperglycemia) and know how to get help.

The signs of **hypoglycemia** (low blood sugar) include:

- | | |
|------------------|---------------------------------|
| • Shakiness | • Anger, sadness, or crankiness |
| • Dizziness | • Feelings of stubbornness |
| • Nervousness | • Clumsiness |
| • Sweating a lot | • Feeling confused |
| • Hunger | • Tingling feeling around mouth |
| • Headache | • Passing out (fainting) |
| • Pale face | • Seizure |

The signs of **hyperglycemia** (high blood sugar) include:

- | | |
|----------------------|--------------------------------------|
| • Frequent urination | • Feeling weak |
| • Extreme thirst | • Blurry vision or can't see clearly |
| • Feeling tired | • Feeling hungry even if just ate |

- b. Children should be allowed to take extra trips to the bathroom or water fountain. This is important because children with high blood sugar may need to use the bathroom more and drink more.
- c. Children should be allowed to check their blood sugar, use their pumps, and give themselves insulin injections if recommended by their health care team.
- d. Staff should provide care during special activities, including sports and field trips.

3. Are there any resources that can help my childcare center learn about diabetes?

Yes. The American Diabetes Association (the Association) has many free educational resources to help staff learn about diabetes and how to provide excellent care to the children in their care. Both parents and childcare center staff can get these resources by calling 1-800-DIABETES (342-2383) or visiting our page on [Training Resources](#).¹

What Are My Child’s Legal Rights in Childcare

4. What are some examples of unfair treatment that may be illegal?

Children with diabetes have the right to enroll and participate in childcare, just like other kids. They also have the right to the care they need to be safe. Unfortunately, parents often face problems like these:

- a. The director of the childcare center your daughter has attended for three years tells you that because she has been diagnosed with diabetes, she is no longer welcome.
- b. Staff members refuse to provide diabetes care, or are not trained in the basics of diabetes care, including giving insulin and glucagon.
- c. You are forced to leave work constantly to come to the childcare center to provide all diabetes care for your son.

5. Are there laws that protect my son or daughter at childcare?

[The Americans with Disabilities Act](#)² (ADA) prohibits childcare centers and camps from treating children with disabilities—including diabetes—unfairly. A **disability** under the ADA is a “physical or mental impairment that substantially limits one or more major life activities.” People with diabetes are considered to have a disability under the ADA because their **endocrine system, a major life activity**, is substantially limited. This is another way of saying your child’s endocrine system does not work correctly because it does not produce and/or use insulin properly. The ADA does not apply to childcare centers run by religious institutions.

If your childcare center receives federal funding, **Section 504 of the Rehabilitation Act of 1973** (Section 504) protects your child. Your rights under this law are much the same as they are under the ADA. Unlike the ADA, Section 504 does not have an exception for religious organizations; if your religiously-operated childcare center receives federal funds, it must follow the law.

6. Which childcare centers have to comply with the ADA and Section 504?

All childcare centers run by state and local governments—including those run by towns, school districts, and public universities—are covered by the ADA. They cannot discriminate, and must give some diabetes care. Some examples include:

¹ www.diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/school-staff-trainings/training-resources.html.

² www.ada.gov/childq%26a.htm.

- A summer day camp run by your town.
- A childcare center at the state university you attend.
- An afterschool program run by your child’s school district.

Private childcare centers are “public accommodations” that must not discriminate against your child under the ADA. Some examples include:

- A childcare center that is a part of a national chain.
- A small childcare center operated out of a person’s home.
- An afterschool program run by the YMCA at your child’s school.

All childcare centers that receive federal funding must comply with Section 504. Head Start is an example of a program that must give Section 504 protections because it receives federal funding.

Childcare centers operated by religious organizations are not covered by the ADA. However, if they receive substantial support from a recipient of federal funding—like holding their programs at public school buildings—they are covered by Section 504. (Even if the ADA and Section 504 do not apply, you can still seek fair treatment for your child. For more information, see the Association’s fact sheet “The Rights of Students with Diabetes at Religious Schools.”)

7. My child cannot self-administer insulin, and she needs someone to administer glucagon if she has a hypoglycemia emergency. Does she have a right to these services?

It depends. Under the ADA, childcare centers may refuse to provide some services if the cost or difficulty of providing the service would be an **undue burden** or it would **fundamentally alter** the nature of the program. The total budget and resources of the center should be taken into consideration. For example, a large childcare chain may have to provide more services than a small family childcare center run out of a home.

Some states have laws that allow trained staff without health care licenses—including aides, teachers, and administrative personnel—to administer insulin and/or glucagon. Childcare centers in these states probably have to provide these services. If a childcare center has a policy prohibiting staff from administering insulin and glucagon, it may need to change the policy to avoid violating the ADA.

Some states only allow doctors and nurses to provide these services. If a particular childcare center can show that hiring a nurse would be an undue burden, there is the possibility that it might not need to provide this care. For example, in one of these states, a small family-run childcare center that cannot afford to hire a nurse might not need to administer insulin or glucagon.

8. Are there any state laws that apply to my child’s rights in childcare?

Maybe. Most states have laws that are similar to the ADA or Section 504. Also, each state has different laws, regulations, and policies that can affect diabetes care in childcare. Many states have specific health or diabetes care laws that protect the rights of children with diabetes. Contact the Association at 1-800-DIABETES (342-2383) if you have questions about the laws in your state.

Resolving Challenges

9. How should I begin the process of getting the right care in place for my child?

- a. **Get in contact with the right childcare center staff.** Find out who is in charge of making sure that the needs of children with special medical needs and disabilities are being met. This may be a nurse, a health aide, a social worker, a director, or even the owner.

- b. **Send supplies.** Make sure your child has all of the equipment, supplies, and snacks necessary to care for his or her diabetes.
- c. **Write it down.** You and the childcare center should make a written plan that includes both the care that your child needs, and how it will be provided. For example, you could plan when to give your child's insulin, and which staff person will administer it. Make sure to get a copy.
- d. **Keep all documents.** This includes emails, letters and medical notes. Keep a log of all relevant conversations, including names and dates.
- e. **Be a resource for the childcare center.** Be ready to answer questions about your child's needs and to work with childcare center staff when necessary. The ADA's website has trainings materials that you can share with your child's childcare center staff and administrators.

10. What steps should I take if my child is not getting fair treatment?

- a. **Educate:** Explain to staff what diabetes is and how it affects your child. Be prepared to give information to prevent problems and also when problems arise. You can do this with a written plan, or through staff training. **The Association has many resources to help.**
- b. **Negotiate:** Try to listen to childcare center staff concerns, and clearly communicate yours. Make sure you know about and participate in all meetings about your child's diabetes. Even after you have a plan in place, you still may need to educate and work with staff to make sure your child's needs are being met. **It is easier if everyone can work out an agreement.**
- c. **Litigate:** If your child continues to be discriminated against, **you have the right to file a complaint or lawsuit.** The process is different for each law and you may need an attorney.
- d. **Legislate:** If the laws are not protecting children with diabetes, the laws might have to change.

11. How can I get help if my child is experiencing discrimination?

If you need help, call us at 1-800-DIABETES (342-2383) and ask how you can speak with an American Diabetes Association legal advocate. These legal advocates are lawyers who specialize in diabetes discrimination issues. They will help you understand the law and your rights. A legal advocate will provide strategies for you to stand up for your rights, give you tools to use to advocate for yourself, help you negotiate an agreement, guide you through the legal process, or, if necessary, help you find a lawyer to take your case.

Many free resources are available in a packet that you can receive by calling 1-800-DIABETES (342-2383). Additional resources are available online at our [Safe at School](http://www.diabetes.org/safeatschool) website.

Important Note: This document describing the legal rights of individuals with diabetes is for your general information and review only. It is not a substitute for the advice of legal counsel.

