



BUILDING A HEALTHY START
Professional Development for Caregivers of Infants and Toddlers

Module One Training Guide: Feeding Infants and Toddlers in Early Childhood Settings

Alabama Department of Public Health

A Series of Six Best Practice Training Modules
Based on *Caring for Our Children:
National Health and Safety Performance Standards;
Guidelines for Early Care and Education Programs,
Third Edition*

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Project Overview

The *Building a Healthy Start: Professional Development for Caregivers of Infants and Toddlers* Project (the Project) is administered by the Alabama Department of Public Health (ADPH) and funded by the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. The Project's purpose is to improve the quality of infant and toddler child care in Alabama by integrating nationally recognized health and safety standards into a professional development project. The Project is comprised of six best practice training modules for caregivers of infants and toddlers to be developed and released over a three-year period. *Feeding Infants and Toddlers in Early Childhood Settings* is the first module in this series and addresses nutrition. Subsequent modules will address physical activity, disaster preparedness, environmental health, social emotional development, and child abuse and neglect prevention. The training modules are based on 28 standards from *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition (CFOC3).

Training module content was researched and written by an early childhood curriculum specialist with experience and expertise in health and safety consultation in early childhood settings and guided by the oversight of an expert work group under the leadership of the project director. Members of the work group include pediatricians, professional development leaders, child care health consultants, early care and education professionals, and leaders from Alabama's Office of Child Care Licensing and its Quality Rating and Improvement System, Alabama Quality STARS. Additional guidance and technical assistance was provided by Barbara U. Hamilton, M.A., the Early Childhood Comprehensive Systems federal grant officer for this Project.

The Project training modules are not intended to be a comprehensive curriculum for caring for infants and toddlers in early childhood settings. Each module addresses a specific issue and focuses on information specific to the care of infants and toddlers related to that issue. A developmental approach is integrated into each module because of its vital importance to optimal health outcomes during the first three years of life. The Project staff and work group members hope that these training modules enhance the knowledge and skills of the caregivers who participate and improve the quality of care that they provide to Alabama's youngest and most vulnerable citizens.

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Instructions for Trainers

Target Training Population

This module is designed to train caregivers of infants and toddlers on feeding infants and toddlers in early childhood settings. Content is appropriate for a variety of early childhood settings, including center- and family-based child care, Early Head Start, Department of Defense community services programs, and teacher preparation programs.

Length of Training

The training module may be taught in one two-hour session or two one-hour sessions at the discretion of the trainer. The length of training is dependent on learning needs and the trainer's preferences regarding utilization of participant activities.

Module Description

The training presentation includes colorful slides to lead participants in discussion relevant to their specific settings and the infants and toddlers in their care. The module includes the following components:

- learning outcomes
- detailed outline of content
- PowerPoint presentation
- instructions for participant activities
- materials list for activities and visual aids
- pre- and post-test questions
- reproducible handouts
- reproducible evaluation forms

The module is packaged on a compact disc. Master copies of participant handouts are included so trainers can make the appropriate number of copies. Trainers are encouraged to select or develop additional handouts to meet specific training needs of each target audience.

The training guide outline is numbered to match the slides. The PowerPoint slide presentation is protected to prevent printing of slides as handouts. Copies of the presentation slides may not be used as handouts.

Equipment

A laptop and projector are needed to project the PowerPoint slide presentation during the training session. A flipchart, chalkboard, or whiteboard may be used during class discussion.

Supplemental Materials

Supplemental materials will be needed by the trainer for participant activities and demonstration purposes to enhance training and facilitate learning. Existing supplies may be utilized or these items may be purchased. Recommended supplemental

materials include the following items:

- Various types of infant formula: ready-to-feed, concentrate, and powder
- Various shapes and sizes of bottles, including at least 4- and 8-oz sizes
- Various types of commercially available nipples
- A life-sized baby doll
- Colorful, toddler-sized tableware: 4 or more plates, bowls, cups, place mats, cloth or paper napkins, and sets of eating utensils

Compliance with National Standards

Information and recommendations presented in these training modules are current and in compliance with national standards and recommendations in effect at the time of publication. Information presented reflects best practice as presented in the following documents:

- American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education (2011). *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs*, 3rd edition.
- Other national criteria or recommendations, as appropriate and relevant to the specific topic.

It is the responsibility of the trainer to review materials prior to presentation, and include any additional information that may be required by state and local regulations.

Training Information Disclaimer

Content is designed to provide information appropriate for early childhood teachers, caregivers, and families. Individual consultation by a child care health consultant or other health care professional may be required to address specific situations or needs. Training information related to illness or injury, medical services, or consumer products is **not** intended for diagnosis or treatment. Questions or situations related to individual children should be referred to an appropriate health care provider.

Instructions for Teaching the Module in Two Sessions

This module may be taught in one two-hour presentation or two one-hour presentations. If the trainer opts to teach the Feeding Infants and Feeding Toddlers sections separately, the introductory slides (1- 8) and concluding slides (55 - 57) should be used at each presentation. The first two learning objectives and the first five pre- and post-test questions pertain to the Feeding Infants section. The final learning objective and last five pre- and post-test questions pertain to the Feeding Toddlers section.

Training Content

1. **Title Slide: Feeding Infants and Toddlers in Early Childhood Settings**

The Alabama Department of Public Health received a grant from the Maternal and Child Health Bureau (#H25MC00238) to focus on the improvement of infant and toddler child care quality in Alabama by integrating nationally recognized health and safety standards into a professional development project. This project, *Building a Healthy Start*, will develop and release six best practice training modules for caregivers of infants and toddlers over a three-year period. *Feeding Infants and Toddlers in Early Childhood Settings* is the first module in this series and addresses nutrition. Subsequent modules will address physical activity, disaster preparedness, environmental health, social emotional development, and child abuse and neglect prevention. The training modules will incorporate 28 standards from *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition (CFOC3).

2. **Introduction**

3. **Learning Outcomes**

At the end of this session, participants will be able to:

- Describe best practice for feeding infants, including promoting breastfeeding;
- Describe developmentally appropriate ways to introduce solid foods and other fluids; and,
- Identify nutritious foods and appropriate servings for toddlers.

4. **Pre-Test**

Please have participants complete the pre-test questions at this time.

5. **Caring for Our Children**

CFOC3 is the definitive source on best practice in health and safety in early care and education settings. These standards are evidence based, have expert consensus, and are nationally recognized as model standards for health and safety practices.

CFOC3 was developed through a collaborative partnership between the:

- American Academy of Pediatrics (AAP).
- American Public Health Association (APHA).
- National Resource Center for Health and Safety in Child Care and Early Education (NRC).

Visit www.nrckids.org to browse the CFOC3 standards. Content for this training session includes standards presented in Chapter 4, Nutrition and Food Service.

Standards that are specifically addressed in this training are listed in Appendix A. Information from additional CFOC3 standards has been incorporated where appropriate.

6. **Standards, Guidelines, and Regulations**

Best practice in child care is based on standards, guidelines, and recommendations.

- **Standard:** A statement that defines a goal of practice. It is usually based on scientific or epidemiological data. A standard is set as the strongest criterion for best practice in a given area by an organization or association.
Examples:
 - CFOC3
 - ASTM International Standards for product safety, such as cribs
- **Guideline:** A statement of advice or instruction. A guideline originates from an organization with acknowledged standing.
Examples:
 - Choose My Plate campaign
 - Let's Move Child Care campaign
- **Regulation:** A standard or guideline that becomes a requirement for legal operation. A regulation originates in an agency with governmental or official authority and is accompanied by enforcement activity.
Examples:
 - Alabama Department of Human Resources (DHR) Licensing Standards
 - Head Start Program Performance Standards
 - U. S. Department of Agriculture (USDA) Child and Adult Care Food Program

NOTE: The content of this module is based on the best practice standards published in CFOC3. These standards may or may not have been adopted as regulations in Alabama. Caregivers should be familiar with state and local child care regulations and operate in compliance with such regulations.

7. **Terminology**

The following terms are used throughout this training session:

- **Parent**—refers to a parent, guardian, or other family member who cares for the child.
- **Caregiver**—refers to an adult who provides out-of-home care for children (e.g., child care).
- **Regular doctor**—refers to a pediatrician, nurse practitioner, or other professional who provides medical and other health care services on a continual basis (medical home).

8. **Importance of Nutrition in Early Care**

Food provides the energy and nutrients needed by infants and children during this critical period of growth and development. Caregivers should provide food each day to meet each child's nutritional needs.

Food should be clean, safe, and developmentally appropriate. Food also should look and taste good!

Clean drinking water should be freely available to children.

Caregivers have the opportunity to observe children's eating patterns in a relaxed and pleasant eating environment. They can work with parents to promote development of healthy eating habits.

9. **Part 1: Feeding Infants**

10. **Breastfeeding is Best!**

There are many benefits of human milk. Human milk:

- Helps fight infection. Human milk contains antibodies from the mother to help protect the infant from some illnesses and conditions.
- Promotes digestion. The major ingredients are sugar (lactose), easily digestible protein (whey and casein), and fat, which are all properly balanced. Human milk also contains vitamins, minerals, and enzymes that aid digestion and absorption of nutrients. Commercial formulas are a good imitation of human milk, but do not contain enzymes, antibodies, and other ingredients.
- Is less expensive and inconvenient. There are no bottles to mix and clean. Human milk is the perfect temperature, and it is always fresh and available.
- Helps prevent childhood obesity, as indicated by many studies.
- Is bacteria-free. Human milk is free of bacteria. Human milk can be expressed into sanitized bottles.
- Promotes nurturing and bonding with direct skin-to-skin contact and is soothing for both infant and mother.

11. **Promote Breastfeeding**

Provide a comfortable environment for mothers to breastfeed or to express milk.

- Privacy should be available, but allow socialization with other mothers if desired.
- Provide a comfortable chair.
- Provide a small blanket to cover infant; launder blanket between uses.

Many mothers will express milk at home or at work. If necessary, provide a private area with an electrical outlet where mothers can express their human milk. This area should not be a bathroom because of sanitation issues.

Participant Activity:

Ask participants to describe their environment for breastfeeding mothers, or how they would suggest enhancing their environment.

12. Expressed Human Milk

Mothers will be instructed in breastfeeding techniques before leaving the hospital with their newborn. A breastfeeding mother can pump and store human milk for bottle-feeding later. WIC and other support groups can counsel new mothers on how to express and store human milk. Commercial breast pumps may be purchased or may be provided by WIC or other resources.

Human milk should be brought to child care in prepared bottles.

Bottles should be clean and sanitized. Use plastic bottles labeled BPA-free or with #1, #2, #4, or #5. Plastic bottles are lighter weight and safer than glass bottles.

Each bottle must be clearly labeled with the infant's full name and the date that the milk was expressed. If human milk was previously frozen, the label should also indicate the date milk was thawed.

Affix labels so they do not come off with water or during handling. Print labels with ink that will not smudge or come off with water or handling. As a safeguard, parents may also write their child's name directly on the plastic bottle with a permanent marker. This practice will identify the bottle in case the label comes off.

13. Storage of Human Milk

Check the date on the label.

- Fresh milk will keep for up to five (5) days, if properly refrigerated.
- Previously frozen human milk must be used within 24 hours of thawing.

Parents may store frozen human milk at home in single use, plastic milk storage bags, clearly labeled with the infant's full name and the date the milk was expressed. Expressed human milk can be frozen for up to six months in the freezer compartment of a refrigerator with separate doors and up to 12 months in a stand-alone (chest/upright) freezer. Frozen human milk should be thawed overnight in the home refrigerator and put in a clean/sanitized bottle the following morning. Label the bottle with the child's full name, the date and time, and "frozen." NOTE: Once thawed, human milk should never be refrozen.

Discard human milk that appears as if it may be contaminated (unsanitary bottle), is curdled, smells rotten, or has not been properly stored/refrigerated.

Return all bottles to the parent at the end of each day.

14. Infant Formula

A parent may use formula instead of, or in addition to, human milk. Commercial formulas are a good imitation of human milk, but do not contain enzymes, antibodies, or other beneficial ingredients found in human milk.

- An infant may need special formula (e.g., iron fortified, soy-based).
- An infant may need supplemental formula if the mother does not have sufficient human milk.
- A mother may choose not to breastfeed or to breastfeed for a limited time. The convenience and flexibility of bottled formula may be necessary.

Parents should consult their child's regular doctor about the initial formula choice and before changing formula or changing brands. There are many different types and brands of formula. Generic or store brand formulas may be equally nutritious and less expensive.

Formula can meet the basic nutritional needs of most infants, but it may be necessary to change formulas. Observe infants for signs of a feeding intolerance, such as being very fussy or gassy, spitting up a lot, having diarrhea, or vomiting. If an infant seems to have a problem with feeding, alert the child's parent and recommend consulting with the infant's regular doctor.

Infants should not have regular cow's milk until they are one year of age.

15. Preparing Formula

Infants should be fed the same type and brand of formula at home and at child care.

Formula provided by the parents should be brought in prepared, labeled bottles.

If parents use powdered formula, it must be mixed at home and brought in prepared, labeled bottles. Caregivers should not mix powdered formula due to sanitation and dilution concerns.

Parents may provide ready-to-feed or concentrated formula in the factory-sealed container, labeled with the child's full name. The formula should be poured into clean, sanitized bottles, also labeled with the child's full name.

Water for formula dilution must be from a source approved by the health department.

To prepare a bottle:

- Wash your hands.
- Use clean and sanitized bottles and nipples.
- Rinse and dry the unopened formula can
- Fill the bottle(s) with formula for one feeding.
- Cover and refrigerate the unused portion.
- Use opened formula within 48 hours.

Participant Activity:

If requested, caregivers may provide information to parents or demonstrate how to safely prepare bottles.

Show various types of formula containers—Ready-to-feed, concentrate, and powder. Have participants demonstrate how to prepare formula in 4- and 8-oz bottles. Indicate level of water (dilution) and formula product.

- Ready-to-feed: pour amount directly into bottle.
- Concentrated: mix formula with water at a 1:1 ratio. For every 1 oz of formula, add 1 oz of water. (Follow instructions on can).
- Powder: Add 1 scoop of formula (scoop provided in formula can) for every 2 oz (4 tablespoons) of water. Mix directly in bottle; shake thoroughly.

Demonstrate measuring utensils. 1 oz = 2 Tablespoons; scoop (level or heaping); show ounce markings on bottles.

16. Bottle Sanitation

For both human milk and formula:

- Each bottle should contain human milk or formula for a single feeding. For young infants, consider using 4 oz bottles rather than 8 oz bottles.
- Encourage parents to transport bottles in insulated cooled bags (e.g., with freezer pack). Upon arrival, bottles should be immediately stored in the refrigerator at a temperature of 39⁰ F (4⁰ C).
- It is recommended that a separate refrigerator be used for infant bottles, infant food, and other infant supplies.
- If a refrigerator is also used for other food storage, then place bottles near the back of the refrigerator on a designated top shelf to avoid contamination by food spillage or drips.
- A bottle should be in the refrigerator until the infant is fed. Bottles should never be left at room temperature.
- Complete the infant's feeding within one hour. After that time, harmful bacteria can grow. Discard unfinished formula and human milk.
- Return all bottles to the parent at the end of the day.

If the program provides formula and prepares the bottles, bottles and nipples should be cleaned and sanitized by (1) washing in an automatic dishwasher, or (2) washing in hot soapy water, then rinsing, and boiling for one minute. Be sure the hole in the nipple is cleaned thoroughly.

Participant Activity:

Show various types of bottles, including size (4 oz vs. 8 oz), shape, and type of nipples. Discuss advantages and disadvantages of each.

Show bottle markings to indicate BPA-free or with #1, #2, #4, and #5.

Show how to clean a bottle and the nipple.

17. The Right Bottle for the Right Infant

Follow procedures to ensure that human milk or formula is given to the correct infant.

- Feed only one infant at a time
- Handle only one bottle at a time.
- Confirm the identity of the infant.
- Check the bottle label twice for the infant's name.

If human milk is given to the wrong infant, caregivers should follow CFOC3 standard 4.3.1.4. The child's parent should be contacted. The caregiver should recommend that the parent contact the child's regular doctor. Document the occurrence in an incident report.

18. Warming Bottles

Bottles can be served cold or at room temperature. Infants who are normally breastfed may be more willing to accept a bottle if it is warmed.

To warm refrigerated bottles:

- Place the bottle in a container of warm water (no more than 120⁰ F) for 5 minutes or less.
- If an electric slow-cooking device or bottle-warmer is used to warm bottles, the device should contain water that does not exceed 120⁰ F. The device and electrical cords must be out of children's reach and positioned away from children's areas. The device must be emptied, cleaned, sanitized, and refilled with fresh water each day.
- Remove the bottle from the water. Dry thoroughly with a disposable towel to prevent the risk of hot water dripping onto the infant.
- Gently swirl or mix (do not shake) the bottle after heating to evenly distribute the warmed milk and prevent "hot spots." Check the temperature by shaking a few drops out onto the back of your hand, which is more sensitive than your wrist. It should feel cool or slightly warm. An infant's mouth and skin are very sensitive. Milk that feels warm to you may be too hot for the infant.

DO NOT microwave bottles! There are many reported cases of serious burns to infants due to microwaved bottles.

- The bottle may seem cool, but the liquid inside may be extremely hot.
- The buildup of steam in the bottle, which is a closed container, could cause it to explode.

19. **Techniques for Bottle Feeding**

Bottle feeding techniques should mimic breastfeeding. If possible, have the same caregiver feed the infant for every feeding.

- Hold the infant during feeding. Caregivers may talk, sing, or croon to infants during feeding. Respond to infant vocalizations with eye contact and vocalizations.
- Make sure the bottle is upright and the nipple is full of human milk or formula.
- Allow the infant to stop during the feeding. Watch for signs of fullness.
- Burp infants after every feeding and during feeding if needed.
- Feeding should be completed within one hour. After one hour, harmful bacteria can begin to grow in the human milk or formula. After feeding, discard unused milk in the bottle.

Caution:

- Do not prop a bottle!
- Do not allow infants to have bottles in the crib.
- Do not allow older infants to carry a bottle while standing or walking around.

20. **Feed on Demand, Not on Schedule**

Infants should be fed on demand. Most infants will be hungry every 3-4 hours. An infant usually needs 3 to 8 ounces of human milk or formula, depending on the infant's age. Newborns and breastfed infants may need to be fed smaller amounts and/or fed more frequently.

Observe infants for signs of hunger, such as sucking on fist, "rooting" actions, or sucking on a pacifier for a few seconds and then crying. If it has been 2-3 hours since the infant was last fed, or if the infant did not consume much at the last feeding and is acting like this, feed the infant. If the infant is finishing a bottle and acting hungry again after a short time, try adding more human milk or formula when preparing bottles.

Let the infant decide when to stop eating. Watch for fullness cues. The infant may seal his lips together, decrease or stop sucking, turn his head away, or fall asleep.

If an infant is sleeping, do not wake him for feeding unless his regular doctor has instructed this for medical reasons.

Refer to handout “Child Care Meal Pattern for Infants.”

21. **Burp Infant after Each Feeding**

When burping an infant, use repeated gentle patting on the infant's back. Try experimenting with different positions that are comfortable for you and the infant:

- Sit upright and hold the infant facing you against your chest. The infant's chin will rest on your shoulder as you support the infant with one hand. With the other hand, gently pat the infant's back.
- Hold the infant sitting up, in your lap or across your knee. Support the infant's chest and head with one hand by cradling the infant's chin in the palm of your hand and resting the heel of your hand on the infant's chest. Use the other hand to pat the infant's back gently.
- Lay the infant on your lap on his belly. Support the infant's head and make sure it's higher than his chest. Gently pat the infant's back.
- Lay the infant on your lap. The infant will be on his back with his head on your knees and his feet on your abdomen. Holding his hands, slowly raise him to a sitting position. (It is not necessary to pat the infant's back while doing this.)

If an infant seems fussy while feeding, stop the session, burp him, and then resume feeding. Burp the infant again when the feeding is completed.

Participant Activity:

Using a life-size baby doll, demonstrate various feeding and burping positions.

22. **Choking on Fluids**

Infants sometimes seem to choke when taking a bottle. They may cough, spit, or even throw up. However, infants almost always recover without assistance.

If an infant appears to choke:

- Take the bottle out of the infant's mouth.
- Hold the infant upright and leaning slightly forward. Support the infant's head and neck.
- Let the infant cough the fluid out.

Do not pat the infant on the back or raise his arms. In severe cases, you may use a bulb syringe to remove fluid; however, this procedure is not usually necessary.

23. **Introducing Other Fluids**

Parents should consult their child's regular doctor about when to add juice and water to the infant's diet. Water is generally not given until after 12 months of age. (*See slide #49 regarding water.*)

Juice may be served in a regular cup to children over 12 months of age.

- Serve only 100% fruit juice, no added sweeteners.

- Serve only juice that is pasteurized. Unpasteurized juice may contain bacteria that can cause serious illness.
- Offer juice at specific meals and snacks as part of the child's regular feeding schedule. Do not offer juice or other sweetened beverages outside of meals or snacks because it may interfere with children's hunger and mealtime nutrition.
- Limit juice consumption to 4-6 ounces per day, including what is offered at home.

Juice is a natural laxative. Too much juice may cause diarrhea.

24. Never Give Honey or Unpasteurized Juice

Honey should not be given to infants under 12 months of age because it can contain the spores that cause botulism. If taken into the infant's digestive system, these spores can release a dangerous, deadly toxin. As well, unpasteurized juice may contain bacteria that can cause serious illness.

Some parents may want their child to have a pacifier. If pacifiers are used, never coat a pacifier with honey or other sweetener.

25. Cow's Milk

- Cow's milk should not be given to infants under one year of age.
- Children ages 12-24 months may have whole pasteurized milk.
- Children over two years of age should be served reduced fat pasteurized milk.

Toddlers need the calories from the whole milk and other fats they ingest. These calories provide the energy needed for their fast rate of development.

After age two, it is appropriate for children to begin to eat fewer high-fat foods. Parents and caregivers should follow the recommendations of the child's regular doctor regarding use of 2%, 1%, or skim milk.

If signs of milk allergy or lactose intolerance are noticed, the child's regular doctor may recommend other milks, such as soy or almond milk.

26. Introducing Cups

Some children may be developmentally ready to feed themselves as early as 6 months of age.

To transition from a bottle, use a small clean cup, with no chips or cracks. Using a regular cup promotes self-feeding skills. Sturdy plastic or melamine cups that can be washed and sterilized, or sanitized in a dishwasher, are recommended. If disposable cups are used, choose sturdy plastic cups that will not easily collapse when the child grasps it. Do not use foam cups (e.g., Styrofoam). Children may bite off a piece of foam, causing a choking hazard.

Sippy cups are not recommended for child care.

27. Introducing Solid Foods

Decisions about the introduction of solid foods are made by parents, with guidance from their regular doctor. Gradual introduction of iron-fortified foods can supplement the infant's diet of human milk or formula. Solid foods may be introduced when the infant is at least 4 months of age, and preferably over 6 months of age.

The first solid foods should be single-ingredient foods. The same foods should be introduced at home and at child care.

- Document when foods are introduced.
- Wait 2-7 days before introducing another new food.
- Document any observed signs of food allergy or food intolerance.

28. Serving Infant Foods

Parents may want to prepare infant foods at home and bring them to the child care program. These foods may be brought in single-serve dishes or in storage containers.

If, however, the child care program provides the infant foods, then the first solid foods offered to infants should be commercially prepared infant foods (without added sugar, fat or salt). Caregivers should not prepare infant foods, such as pureed fruits or vegetables, on site.

Regardless of whether the food is brought from home or commercially prepared, the food should be served to the infant using a feeding dish and spoon.

- Wash the infant food container with soap and water before opening.
- After opening, check the rim of a glass container for chips or cracks.
- Do not feed from the container.
- Use a clean spoon to place a portion of the infant food on a clean dish. Examine food for glass pieces or foreign objects.
- Immediately cover and refrigerate unused portion. Discard unused portions after 24 hours. Feed only one infant at a time.

Use a small, soft-tipped spoon that fits the infant's mouth and serve tiny amounts. Allow the cereal or other food to flow off the spoon into the mouth. This is a new experience for infants; they may spit out the first few bites.

29. Increasing Solid Foods

Gradually progress to serving foods with more texture. These foods may be commercially prepared or may include soft, cooked, and mashed table foods.

At 10-12 months of age, begin letting the infant feed himself (finger foods). This stage of development, although messy, is a developmental milestone for the infant.

30. Prevent Choking on Foods

- Do not mix cereal in a bottle. Mix cereal with human milk or formula in a dish and serve with a spoon.
- Mash or puree solid foods. Foods for infants should be ¼ inch or smaller.
- Use an infant spoon. Give tiny bites.
- Supervise older infants learning to feed themselves. The caregiver should be seated within arm's reach.

If any respiratory distress – call 911!

31. Part 2: Feeding Toddlers

If teaching both Part 1 and Part 2 in the same training session, a break may be taken here.

32. Meal and Snack Patterns

- Children should be offered nutritious meals and snacks each day, based on the length of time they are in child care each day.
 - If 8 hours or less, serve at least one meal and two snacks, or two meals and one snack.
 - If over 8 hours, serve at least two meals and two snacks, or one meal and three snacks.
- If breakfast is not served by the child care program, then communicate with parents to be sure every child is offered breakfast.
- Toddlers need frequent small servings of foods (meals and snacks) to provide their total daily nutritional intake. They need to eat every three to four hours. The USDA requires 2 ½ hours between meals (e.g., breakfast and lunch), and 1 ½ hours between meals and snacks (e.g., lunch and afternoon snack).

Refer to handout “Child Care Meal Pattern for Toddlers.”

33. Allow Sufficient Time for Each Child to Eat.

Allow sufficient time (e.g., 20-30 minutes) for each child to eat. If a child does not complete his meal, he will probably be hungry and will eat when the next meal or snack is provided.

Discuss what to do if a child is a very slow or a very fast eater.

- Slow eater: Gently remind the child that “You have five more minutes” or give other reminder of time. After the 30 minutes, take the food away and involve the child in other classroom activities.
- Fast eater: Encourage all children to chew, taste, and enjoy the foods. Involve children in pleasant mealtime conversation. If a child has completed his meal, it is not necessary for him to remain at the table.

34. Plan the Menu

Meals and snacks should contain at least the minimum amount of foods shown in the meal and snack patterns for toddlers and preschoolers described in the Child and Adult Care Food Program (CACFP).

35. Breakfast

1 milk (½ cup)

- Whole milk up to age 2 years, reduced fat milk after age 2 years

1 fruit/vegetable (¼ cup)

- Juice, fruit, and/or vegetable

1 grain/bread

- Bread, cornbread, biscuit, muffin, roll (½ slice)
- Hot or cold cereal (¼ cup)
- Pasta, noodles, or grains (¼ cup)

Permit one or more additional servings of nutritious foods as needed to meet caloric needs of individual children.

36. Lunch and Supper

1 milk (½ cup)

- Whole milk up to age 2 years, reduced fat milk after age 2 years

2 fruits/vegetables (¼ cup)

- Juice, fruit, and/or vegetable

1 grain/bread

- Bread, cornbread, biscuit, muffin, roll (½ slice)
- Hot or cold cereal (¼ cup)
- Pasta, noodles, or grains (¼ cup)

1 meat/meat alternative

- Meat, poultry, fish, cheese, and meat alternative (1 oz)
- Egg (½ egg)
- Cooked dry beans or peas (¼ cup)
- Peanut and other nut/seed butters (2 Tbsp)
- Yogurt (4 oz)

Permit one or more additional servings of nutritious foods as needed to meet caloric needs of individual children.

NOTE: Nuts and seeds (½ oz) may be used during lunch and supper as a meat alternative in the CACFP, but nuts may only be served to preschoolers aged 4 or more years in licensed child care centers and homes in Alabama.

37. Snacks

Select two of the four items

1 milk (½ cup)

1 fruit/vegetable (½ cup)—Note that this *is a larger serving size than for a meal*

1 grain/bread (½ slice or ¼ cup)

1 meat/meat alternative—Note that this *is a smaller serving size than for a meal*

- Meat, poultry, fish, cheese, and meat alternative (½ oz)
- Egg (½ egg)
- Cooked dry beans or peas (1 Tbsp)
- Peanut and other nut/seed butters (1 Tbsp)
- Yogurt (2 oz)

NOTE: Nuts and seeds (½ oz) may be used as a meat alternative for a snack in the CACFP, but nuts may only be served to preschoolers aged 4 or more years in licensed child care centers and homes in Alabama.

38. Choose Lower Fat, Sugar, and Sodium

Infants and toddlers need some fat in their diet. Fat is essential for development, including brain development.

Do not add salt when cooking. Remove the salt shaker from the table. Limit foods that are high in salt and low in nutrients.

Limit high sugar and low nutrient foods such as cookies, candy, and cake. Limit sweetened beverages; offer water, milk, or juice.

39. Healthy Eating

There are basic premises for healthy eating.

Portion control.

Enjoy your food, but eat less.

Eat a variety of foods.

Varied foods will differ in the following ways:

- Food group (i.e., dairy, protein, fruit, vegetable, grains).
- Color (e.g., red apples, green pears, red tomatoes, yellow squash).
- Texture (e.g., wheat bread, cooked and raw vegetables, soft banana, crisp celery).
- Shape (e.g., long zucchini, round biscuit, sliced bread, grated carrot).
- Method of preparation (e.g., steamed, grilled, fried, baked, raw).
- Temperature (e.g., cold milk, warm bread).
- Size (e.g., compare size of a strawberry, a kiwi, and a banana).

Choose healthy and nutrient-dense foods.

Healthy foods are those that supply a significant amount of nutrients (vitamins and minerals as well as energy) in amounts appropriate to meet children's growth and development.

- Make half the plate colorful fruits and vegetables.
- Make half the plate grains and proteins. Whole grains and lean protein are recommended.
- Choose reduced fat milk.
- Choose foods lower in salt (sodium).
- Drink water instead of sweetened drinks.

40. Food Safety and Sanitation

Both commercially prepared foods and foods prepared on site should meet safety, sanitation, and nutritional values in accordance with the program's written policy and in accordance with applicable standards and guidelines (e.g., DHR licensing, USDA's CAFCP, health department, etc.).

Foods brought from home:

- Should meet the nutritional and food safety requirements of the program's written policy. Foods from home must be clearly labeled with the child's full name, the date, and the type of food.
- Should not be shared with other children.
- Should adhere to program policy, including food restrictions (e.g., "peanut-safe" environment).

Caregivers should have food available to supplement a child's food brought from home if the food is deficient in meeting the child's nutrient requirements.

41. Self-Feeding Skills

Young toddlers are beginning to develop self-feeding skills. At first, toddlers may sit in high chairs as the caregiver helps them learn to feed themselves. Caregivers should be seated within arm's reach of each child.

As toddlers develop gross motor control, they will be more able to sit and eat at a table with other children.

- Child-size table and chairs should be provided.
- If children seem to slip in chairs, it may help to place rubber matting in the chair seat.
- Rubber matting may also help keep plates and bowls from slipping on the table.

Start with finger foods and foods that "stick" to the spoon. Help children learn to use eating utensils.

Use appropriate utensils including a child-size spoon (short handle with a shallow bowl like a soup spoon) and a child-size fork (short, blunt tines and broad handle

similar to a salad fork).

Mealtime will be messy as toddlers develop self-feeding skills! Encourage children through positive verbal and non-verbal cues—smile!

42. Family Style in Child Care

“Family style” is defined as adults and children eating together, sharing the same menu, and talking together in an informal way. Family-style dining promotes decision making, self-help skills, and sharing and social skills.

Often in food service, “family style” dining means that serving bowls are on the table and passed around. If the child care program has concerns about the safety or practicality of passing serving dishes, particularly hot foods, with toddlers, it is not necessary to pass serving dishes to implement a “family style” approach.

Some important ways to integrate “family style” in child care include:

- Have children and adults sit together at tables. Provide child-size table and chairs.
- Help children develop self-feeding skills. Begin with finger foods and progress to use of age appropriate utensils.
- Offer appropriate portions at least two times.
- Model and begin development of table manners (e.g., please, thank you, passing foods).
- Encourage conversation on topics that children enjoy.
- Allow children who finish eating early to spend time in a learning center or other quiet activity in a supervised area.

Consider sanitation.

- Wash and sanitize tables before and after eating.
- Wash hands before and after eating.

Participant Activity

Have participants discuss “whose family?” Be aware of and respectful that families eat in different ways. Some families sit together, some eat “on the run,” some eat throughout the house (e.g., bedroom, living room, and kitchen). All family styles are okay.

Refer to the handout “SET THE TABLE FOR SUCCESS: Integrating Family Style Dining into Child Care.” This handout provides many suggestions on how to integrate family style dining. Emphasize that caregivers may incorporate any or all of these suggestions.

43. Table Settings

- Use small plates, small cups, and child-size utensils.
- Use silverware and institutional dishware as best practice. Plastic or melamine dishes that can be adequately sanitized are recommended.

- Do not use foam cups and flimsy plastic utensils. Children can bite off pieces of foam cups and break plastic forks and spoons. These broken pieces can cause choking.
- Do not use dishes and cups with chips or cracks.
- Avoid handmade dishes or pottery from outside the U.S. that may contain lead.
- Choose easy-to-grasp serving utensils that offer appropriate portions.
- May use rubber matting to keep bowls from slipping.

Encourage children to help with table settings. Children can also help with clean-up by disposing of trash.

Participant Activity:

Place colorful plates, cups, place mats, cloth or paper napkins, and eating utensils in one place. Have four or more of each item.

Ask four participants to set the table. Each participant should set their table the way they want to do so (i.e., think as a child). This is an individual choice, not a group decision.

Compare the different table settings.

44. Adults Provide – Children Decide

Caregivers should provide nutritious appetizing food in appropriate settings and then allow children to decide how much they eat at each meal or snack.

Help children begin to learn their hunger and fullness cues. Encourage them to eat when hungry and stop when full. This awareness promotes healthy eating decisions to last throughout life.

45. Picky Eaters

Toddlers' eating habits are unpredictable. Observe their eating habits week-by-week, rather than day-by-day. If offered nutritious and appetizing foods, most children will meet their nutritional needs and grow adequately.

Toddlers are often resistant to trying new foods. Encourage, but do not force, children to taste foods or to put foods on their plates. Many attempts—perhaps as many as 15—may be necessary before a child may decide to taste the food or decide if he likes or dislikes it.

To promote healthy eating:

- Serve all foods and beverages at one time.
- Serve a variety of nutritious foods, prepared in appetizing ways. Include at least one food each child likes as part of a meal.

- Offer each food to each child at least two times during the meal. Encourage the child to put food on the plate, even if he does not taste the food. If children are allowed to make choices, they will likely eat more.
- Help children learn to take small servings. Allow a second serving if a child is still hungry.
- Prepare foods in different ways. Vegetables can be eaten cooked, raw, with or without cheese, in a casserole, in salad, etc. Fruits may be raw, sliced or whole, cooked, added to other foods, in salad, etc.
- Present new foods when the child is most hungry or offer new foods as part of an activity.

46. Never Use Food as a Reward or Withhold Food as Punishment

- Encourage a child to eat or try foods. Food should never be forced!
- Offer all foods at one time, including fruits. Do not identify “dessert” foods.
- Do not delay a child’s snack or meal based on completing tasks.
- Give all children the opportunity to participate in all food-related activities.

47. Risk for Choking

Toddlers may be at greater risk for choking because they:

- Do not chew long enough.
- May not have back teeth to grind foods.
- Try to swallow too much food at one time.
- May have difficulty swallowing liquids and solids together.
- Have too much activity during eating.

48. Prevent Choking

- Cut, shred, or prepare foods to reduce risk. Food pieces for toddlers should be ½ inch or smaller.
- Make sure that children are seated when eating.
- Supervise children while they are eating.

49. Choking Hazards

Examples of foods that may cause choking:

- Round: hot dogs and meat sticks, hard candies, grapes
- Hard: nuts, raw vegetables
- Tough: chunks of meat
- Sticky: spoonful of peanut butter or nut butter, marshmallows, clumps of raisins
- Dry: popcorn, pretzels
- Slippery: ice cubes
- Non-edible parts: fish with bones, fruits with pits

50. Water is the Best Thirst Quencher

Encourage children to drink water throughout the day, especially during warm weather or when actively playing.

- Serve cold water with, or without, ice.
- Add ice cubes flavored with small amounts of juice.
- Squeeze in a little lime or lemon juice. Add a sprig of mint.
- Offer a small cup of water, in addition to milk, to drink with meals.
- Have a small pitcher of water for children to pour themselves.

51. Identify and Document Dietary Modifications

Dietary modifications may be needed to promote an individual child's health. Modifications may include avoidance of specific foods or ingredients (e.g., allergy), caloric intake, preparation of food (e.g., pureed), or adaptive feeding utensils. If possible, child care programs should accommodate documented medically required dietary modifications.

Several diseases and conditions—such as food allergy, inability to digest certain foods, need for extra calories, need for special positioning while eating, diabetes, celiac disease, and phenylketonuria (PKU)—may require dietary modification.

Be sure to clearly identify and document required dietary modifications.

Parents should provide a written history that contains any special nutrition or feeding needs for the child. Discuss this history with the child's parents and clarify how child care program feeding routines may differ from home feeding routines.

Obtain written documentation and instruction from the child's regular doctor. Documentation should include the following:

- Child's full name and date of instructions.
- Child's special needs.
- Any dietary restrictions based on the special needs.
- Any special feeding or eating utensils.
- Any foods to be omitted from the diet and any foods to be substituted.
- Limitations of life activities.
- What, if anything, needs to be done if the child is exposed to restricted foods.

As needed, individual feeding plans and program menus related to special nutritional needs may be developed in consultation with the child's parent(s), the regular doctor, a nutritionist/registered dietitian, and other professionals (e.g., nursing and speech and occupational therapy).

52. Food Sensitivity

A child may have an adverse reaction to a food due to food allergy or an inability to digest or tolerate certain foods.

Most adverse reactions to food are caused by 8 food items:

- Peanuts

- Tree nuts
- Shellfish
- Fish
- Eggs
- Milk
- Soy
- Wheat

Signs of food sensitivity can include, but are not limited to:

- Eyes: itching, tearing, redness and swelling of the eyelids
- Nose: sneezing, runny nose, nasal congestion, and nasal itching
- Skin: mild skin redness, red bumps (hives) anywhere on the body, itching
- Gastrointestinal (GI) tract: abdominal pain, nausea, vomiting, diarrhea
- Headache, light-headedness
- Inappropriate behavior, inattention, mood swings

If a child can potentially have a severe allergic reaction (i.e., anaphylaxis) to a food ingredient, then caregivers may attempt to eliminate that food from the program and facility. For example, some children have severe peanut allergies, so the program may attempt to create a “peanut-safe” environment.

The term “peanut-safe” is more appropriate than “peanut-free” because it may be impossible to totally eliminate all traces of a particular food. Food residue may enter the environment from outside food sources (e.g., what another child had for breakfast, foods from home, etc.).

Caregivers must be trained in procedures to follow if a child is exposed to a food trigger. Children with a history of anaphylaxis or severe allergy may have prescribed epinephrine.

53. Cultural and Religious Preferences

Caregivers are not required to accommodate dietary modifications based on personal preference. However, caregivers may accommodate dietary modifications based specific cultural and religious preferences.

Modification may involve restriction of certain foods at all times (e.g., vegetarian or kosher diet), or a parent may request food restrictions only on specific days or during religious or other events during the year (e.g., Lent).

Dietary modifications must still meet the child’s daily nutritional needs. Ask the parent/family for written information about specific dietary modifications and discuss whether the request can be accommodated.

54. Feeding Adaptations for Children with Special Needs

Children with special health care needs may have individual requirements related to diet and swallowing. Food, eating style, food utensils, and equipment, including furniture, may have to be adapted to meet the developmental and physical needs of individual children.

These situations require individual planning prior to the child's entry into the program.

Caregivers must be trained in procedures to follow if a child has an emergency, such as choking.

55. Promoting Healthy Eating

Promoting healthy eating in early childhood forms the basis for a lifetime of healthy eating!

Refer to the handout "Additional Resources for Feeding Infants and Toddlers in Early Childhood Settings."

56. Post-Test and Evaluation

Please have participants complete the post-test questions and training evaluation at this time.

57. Thank You

Thank the attendees for their participation in the training session.

The training module team may follow up with participants in three months to see how they have used this information. A short post-training survey may be sent to the participants at the address provided during registration.

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APPENDIX A

Specific CFOC3 Standards Used in the Development of Module 1

1. Standard 4.3.1.1. General Plan for Feeding

At a minimum, meals and snacks the facility provides for infants should contain the food in the meal and snack patterns of the Child and Adult Care Food Program (CACFP). Food should be appropriate for the infant's individual nutrition requirements and developmental stages as determined by written instructions obtained from the child's parent/guardian or primary care provider.

The facility should encourage, provide arrangements for, and support breastfeeding. The facility staff, with appropriate training, should be the mother's cheerleader and enthusiastic supporter for the mother's plan to provide her milk. Facilities should have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed, as well as a private area with an outlet (not a bathroom) for mothers to pump their breast milk. A place that mothers feel they are welcome to breastfeed, pump, or bottle feed can create a positive environment when offered in a supportive way.

Infants may need a variety of special formulas such as soy-based formula or elemental formulas which are easier to digest and less allergenic. Elemental or special non-allergic formulas should be specified in the infant's care plan.

Age-appropriate solid foods (complementary foods) may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs. For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months to complement the human milk.

2. Standard 4.3.1.3. Preparing, Feeding, and Storing Human Milk

Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant's full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival.

The mother's own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother's written permission.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child's full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother's milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant's full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard, should be returned to the mother.

Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child's fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.

3. Standard 4.3.1.5. Preparing, Feeding, and Storing Infant Formula

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed

and dried. Caregivers/teachers should read and follow the manufacturer's directions. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines at <http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html> (8). The local WIC program can also provide instructions.

Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child's primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child's full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child's full name, and may be stored in the refrigerator for up to twenty-four hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child's full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer's instructions for mixing and storing of any formula preparation.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant's care plan, on how to prepare the formula.

4. Standard 4.3.1.11. Introduction of Age-Appropriate Solid Foods to Infants

A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child's parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs.

For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement the human milk. Modification of basic food patterns should be provided in writing by the child's primary care provider.

Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals.

5. Standard 4.3.2.2. Serving Size for Toddlers and Preschoolers

The facility should serve toddlers and preschoolers small-sized, age-appropriate portions and should permit children to have one or more additional servings of the nutritious foods that are low in fat, sugar, and sodium as needed to meet the caloric needs of the individual child. Serving dishes should contain the appropriate amount of food based on serving sizes or portions recommended for each child and adult as described in the Child and Adult Care Food Program (CACFP) guidelines at http://www.fns.usda.gov/cnd/care/ProgramBasics/Meals/Meal_Patterns.htm. Young children should learn what appropriate portion size is by being served in plates, bowls, and cups that are developmentally appropriate to their nutritional needs.

Food service staff and/or a caregiver/teacher is responsible for preparing the amount of food based on the recommended age-appropriate amount of food per serving for each child to be fed. Usually a reasonable amount of additional food is prepared to respond to a child or children requesting a second serving of the nutritious foods that are low in fat, sugar, and sodium.

6. Standard 4.5.0.10. Foods That Are Choking Hazards

Caregivers/teachers should not offer to children under four years of age foods that are associated with young children's choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).