

**1999 DRAFTING REQUEST**

**Bill**

Received: **02/18/99**

Received By: **malaigm**

Wanted: **As time permits**

Identical to LRB:

For: **Carol Kelso (608) 266-0485**

By/Representing: **Christian**

This file may be shown to any legislator: **NO**

Drafter: **malaigm**

May Contact:

Alt. Drafters:

Subject: **Children - day care**

Extra Copies:

**Pre Topic:**

No specific pre topic given

**Topic:**

Child care; require providers to have training in the prevention of sudden infant death syndrome

**Instructions:**

See Attached

**Drafting History:**

<u>Vers.</u>	<u>Drafted</u>	<u>Reviewed</u>	<u>Typed</u>	<u>Proofed</u>	<u>Submitted</u>	<u>Jacketed</u>	<u>Reaured</u>
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/1			martykr 02/22/99	_____	lrb-docadmin 02/22/99	lrb-docadmin 03/9/99	

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# Carol Kelso

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## Wisconsin State Legislature 88th Assembly District Representative

Gordon,

Rep. Kelso is considering a bill to address the way child care providers are certified in Wisconsin. Recent medical studies have shown that instances of Sudden Infant Death Syndrome (SIDS) can be reduced dramatically by positioning sleeping infants in the supine position, rather than in the prone position (on their stomachs - see attachment). Rep. Kelso would like this information to be included in training and certification for child care providers in Wisconsin.

Current state law allows for the requirements for child care certification to be determined by the department of workforce development (Section 48.65 1) under s. 49.155( Id). These requirements, outlined in the Wisconsin Administrative Code under HFS 55.61 “Standards for family day care and in-home day care”, do not include training or notification for sleeping baby position. (This would probably fit under 55.61(11) - REST).

Adding this provision allows for two options - at the most, the bill would codify into state law the current child care certification standards. We would like to take HFS 55.61 and place all of the language in the state statutes in place of 49.155(1d). This would also require amendment of 48.651 to eliminate reference to the DWD (it can still reference 49.155 (Id), because it would consist of the new language).

If this is too seismic a shift in state law, we would at least like to add a provision to 49.155(d) which would continue to allow the DWD to set the requirements, but “with the most current medical information available regarding Sudden Infant Death Syndrome”.

We feel that child care standards should be included in state law, and not determined by an unelected third party. Additionally, adding the SIDS instruction would save lives, no small feat in itself. Please get back to our office with any thoughts or suggestions you might have.

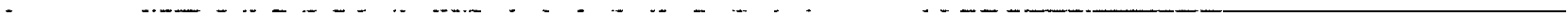
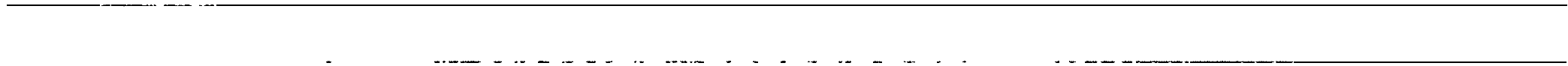
Thanks,

Christian Schneider  
Rep. Carol Kelso’s office

**Office:** P.O. Box 8952, State Capitol • Madison, Wisconsin 53708-8952  
(608) 266-0485 • Toll-Free: (888) 534-0088 • [Rep.Kelso@legis.state.wi.us](mailto:Rep.Kelso@legis.state.wi.us)

**District:** 416 E. Le Capitaine Circle • Green Bay, Wisconsin 54302 • (920) 468-8025

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Section: What's New in Research

## **SUPINE POSITION MAY REDUCE *SIDS* INCIDENCE**

In a survey of 1,000 caregivers of infants, rates of sudden infant death syndrome (***SIDS***) declined significantly among infants who were placed supine instead of in the prone position to sleep. The survey took place from 1992 to 1996. In **1992**, **70** percent of infants were placed in the prone position, prior to the recommendation from the American Academy of Pediatrics that infants be placed in a supine position to help prevent ***SIDS***. By 1996, only 26 percent of infants were being placed in a prone position.

Between 1992 and 1996, ***SIDS*** rates declined by about 38 percent. Although causality cannot be established definitively, the researchers state there probably is a correlation between a decrease in ***SIDS*** and an increase in the number of infants placed in a supine position. They recommend that more reductions in ***SIDS*** could be accomplished by promoting a supine sleeping position among caregivers at high risk for placing infants in a prone position. In the study, those high-risk caregivers were more likely to be AfricanAmerican, younger than 29, living in southern or mid-Atlantic states and having had a previous child.

Willinger M, Hoffman HJ, Kuo-Tsung W, et al.: Factors associated with the transition to **nonprone** sleep positions of infants in the United States. Journal of the American Medical Association 1998; 280: 329-335. For reprints, contact **Marian** Willinger, Ph.D., National Institute of Child Health and Human Development, Center for Research for Mothers and Children, Pregnancy and Perinatology Branch, Executive Building, Room **4803**, **6100** Executive Blvd., MSC 7510, Bethesda, MD 2089275 10. E-mail: [mw75q@nih.gov](mailto:mw75q@nih.gov).

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**Source:** Brown University Child & Adolescent Behavior Letter, **Oct98**, Vol. 14 Issue 10, **p3**, 1/4p.

**Item Number:** **1255666**



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Section: World News

## Pediatrics

# INFANT SLEEPING POSITION: PREGNANCY RISK ASSESSMENT MONITORING SYSTEM

In 1992, the American Academy of Pediatrics recommended that all healthy babies be put to sleep either on their backs or sides to reduce the risk of death, from sudden infant death syndrome (**SIDS**), the leading cause of post-neonatal (one to 11 months of age) deaths in the United States.

In 1996, 3,050 infants, under one year of age, died from **SIDS**, said the U.S. Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health **SIDS** rates for black and American Indian infants was two to three times higher than for whites. In 1994, a national "Back to Sleep" educational campaign was launched to encourage the public and health care providers to put babies to sleep on their backs or sides, and to avoid putting them on their stomachs.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, state-based surveillance system of maternal behaviors that occur before, during, and after pregnancy, including the child's early infancy.

Population-based data on the usual infant sleeping position for 1996 births, by race, from 10 states participating in the PRAMS (Alabama, Alaska, Florida, Georgia, Maine, New York, Oklahoma, South Carolina, Washington, and West Virginia) showed that the percentage of respondents who reported usually putting their babies to sleep on their stomach varied by state from 16.0 percent to 30.8 percent, the CDC reported.

3 In most states, most respondents usually put their babies to sleep on their sides, which is recommended over the stomach sleep position, but is not as effective in reducing the risk of **SIDS** as the back Sleep position. In five southern states, the prevalence of the stomach sleep position was about two-fold higher than in the states having the lowest percentages (Maine and Washington). The percentage of respondents who reported putting their babies to sleep on their back was the highest in **Washington** (42.9 percent) and Alaska (40.8 percent), and lowest in Georgia (24.5 percent), Florida (25.4 percent), and South Carolina (25.8 percent):

According to CDC, black mothers were more likely (11-54 percent higher) than white mothers to put their babies to sleep on their stomach. Among black mothers, the percentages ranged from 22.5 percent in Washington to 42.1 percent in Florida; white mothers from 16.1 percent in Maine to 30.5 percent in Oklahoma.

Data for American Indians in two states, Washington and Oklahoma, indicated that 16.0 percent and 33.9 percent of respondents, respectively, reported usually putting their babies down to sleep on their stomachs. The comparable percentage for Alaskan Natives was 23.5 percent.

The national goal of the "Back to Sleep" campaign is to reduce the percentage of infants put to sleep on their stomachs to 10 percent or less by the year 2000. According to the National Infant Sleep Study, 24 percent of U.S. infants are put to sleep on their stomachs.

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By Keith Key, News Editor

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**Source:** Health Letter on the CDC, 1 1/09/98-11/16/98, p9, 2p.

**Item Number:** 1257835

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## SUDDEN INFANT DEATH SYNDROME --- UNITED STATES, 1983-1994

Sudden infant death syndrome (**SZDS**) is “the sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history” ( 1 ). Although **SIDS** is a diagnosis of exclusion and of unknown etiology, it is the leading cause of postneonatal mortality in the United States, accounting for approximately one-third of all such deaths (2). This report analyzes age-, race-, and region-specific trends for **SZDS** in the United States during 1983-1994 (the latest year for which final data are available) and indicates that annual rates of **SZDS** declined more than three times faster during 1990-1994 than during 1983-1989.

Data about deaths attributed to **SIDS** and data about autopsy rates are from U.S. public-use mortality data tapes compiled by CDC (3) and include infants (aged <365 days) who were born to U.S. residents and died from **SIDS** (listed as the underlying cause of death) (International Classification of Diseases, Ninth Revision [ICD-9], code 798.0). Death rates were estimated as the number of these deaths divided by the number of live-born infants during the same period; data about live:born infants are from published natality statistics (4). To characterize **SZDS** trends, annual data were combined so that the rate of **SZDS** for 1983- 1989 could be compared with the rate for 1990--1994; these periods were selected for comparison because of the implementation during the 1990s of efforts that potentially influenced diagnosis and reporting of **SZDS** (e.g., increased awareness among heal&care providers about risk factors for **SZDS**, revision of the definition of **SZDS**, and initiation of national **SZDS** prevention efforts). Race for infants who died from **SZDS** was determined by the race of each infant, and race for all live-born infants was determined by the race of the mother. Differences are presented only for black and white infants because the mortality data tapes do not provide accurate race data for other racial/ethnic groups. The linked infant birth-death data set provides accurate race data from birth certificates but is available only through 1991. Neonatal deaths are deaths among infants aged <28 days, and postneo-natal deaths are those among infants aged 28-364 days.

During 1983-1994, **SZDS** was listed as the underlying cause of death for 61,882 infants (Table 1). During 1983-1990, the rate of **SZDS** decreased an average of 1.6% per year; during 1990- 1994, the rate decreased an average of 5.6% per year.

Most **SZDS** cases occurred during the postneonatal period; 93.7% and 92.4% of **SZDS** cases occurred in this age group in 1994 and 1983, respectively. The postneo-natal **SZDS** rate was 13.9% lower during 1990-1994 than during 1983-1989 (112.9 versus 131.1 per 100,000 live-born infants, respectively). Rates for **SZDS** were highest among infants aged 1-3 months at death (Table 2): in 1994, deaths in this age group accounted for 68.4% of all **SZDS** cases.

From 1983-1989 through 1990-1994, the **SZDS** rate for female infants declined 16.5% (from 114.7 to 95.8 per 100,000 live-born infants), and the rate for male infants declined 13.5% (from 166.0 to 143.6). Male infants were 45% and 50% more likely to die from **SIDS** than female infants during 1983-1989 and 1990-1994, respectively.

From 1983-1989 through 1990-1994, the **SZDS** rate for black infants decreased 10.4% and the rate for white infants decreased 16.7%. The average annual decline in the rate of **SZDS** for black infants was 2.1% during 1983-1990 and 4.1% during 1990-1994. For white infants, the decreases for the two periods were 1.4% and 6.3%, respectively. The rate for black infants was 2.0 and 2.2 times that for



white infants during 1983-1989 and 1990-1994, respectively.

Decreases in the **SIDS** rate during the two time periods also varied by region\*. Decreases were greater in the West (23.0%) and Northeast (18.7%) than in the Midwest (11.5%) and South (10.2%). During 1983-1989, **SIDS** rates were 195.2 per 100,000 live-born infants in the Midwest, 166.8 in the West, 135.5 in the South, and 80.7 in the Northeast; during 1990-1994, the respective rates were 172.8, 128.4, 121.7, and 65.7. During 1983-1989, infants in the Midwest were 2.4 times more likely than infants in the Northeast to die from **SIDS**; during 1990-1994, the ratio was 2.6.

The percentage of deaths attributed to **SZDS** that were followed by an autopsy increased from 85.8% in 1983 to 93.4% in 1990 and to 95.7% in 1994. The percentage of autopsies were similar by race but differed by region. In 1983, 25.7% of deaths attributed to **SIDS** in the South were not followed by an autopsy, compared with <15% in other regions. By 1994, this percentage had declined to 6.8% in the South and <3% in other regions.

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Vital Statistics, National Center for Health Statistics, CDC.

Editorial Note: The findings in this report indicate that the decline in the rate of **SIDS** was greater during 1990-1994 than during 1983-1989. For the first time since 1980, in 1994, **SIDS** declined from the second to the third leading cause of infant mortality. In addition, preliminary mortality data for 1995 indicate that the **SIDS** rate declined 18.3% from 1994, representing the largest annual percentage decline since 1983 and suggesting that the higher rate of decline observed during 1990-1994 is continuing (2). This trend may reflect changes in the prevalence of known risk factors and/or changes in the diagnosis of **SIDS**.

Many of the risk factors for **SIDS** identified during the 1980s (e.g., low birthweight, young maternal age, and poor socioeconomic status) are not readily amenable to intervention (5). However, a strong association between the infant prone sleeping position and **SIDS** had been established by 1990 (6). → During 1992, the American Academy of Pediatrics began recommending that parents place infants on their back or side to sleep (7), and during 1994, the national "Back to Sleep" campaign (6) began promoting the nonprone sleeping position as well as other modifiable risk factors (e.g., breastfeeding was encouraged and exposure to tobacco smoke and overheating was discouraged). Studies in other countries indicated that **SIDS** rates declined approximately 50% concurrent with decreases in the prevalence of prone sleeping (6). In the United States during 1992-1995, the **SIDS** rate declined 30% concurrent with a decrease in the prevalence of prone sleeping from 78% in 1992 to 43% in 1994 (6). Although the prevalence of breastfeeding did not change substantially during the study period (8), birth-certificate data indicate that during 1989-1994, the prevalence of cigarette smoking during pregnancy declined by approximately 25% (from 19.5% to 14.6%) (9).

Race/ethnicity-specific differences in **SZDS** most likely reflect variations in the prevalence of risk factors for **SZDS**, including socioeconomic and demographic factors, certain medical conditions (e.g., prematurity), and the quality of and access to health care (5). However, because race/ethnicity-specific prevalences of prone sleeping during the early 1990s are unavailable, the effectiveness of campaigns to discourage the prone sleeping position could not be evaluated by race/ethnicity. Regional differences in **SIDS** rates may reflect differences in the prevalence of risk factors as well as variations in state protocols for investigating suspected cases of **SIDS**.

Based on preliminary data, the black/white ratio for **SIDS** in 1995 (2.4) was higher than during any



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other year since 1983, indicating that racial/ethnic disparities in **SIDS** may be increasing. Because of persistent race-specific differences in risks for **SIDS**, prevention efforts should be targeted especially to black infants. In addition, evaluation efforts should assess whether race-specific and regional differences are related to variations in the prevalence of preventable risk factors, in methods of diagnosis, or in the effectiveness of prevention messages.

Before 1991, only an autopsy was required for the diagnosis of **SIDS**. During 1991, the official definition of **SIDS** was revised to require an investigation of the death scene (1), although this change may not have been uniformly implemented by all state/local health departments. However, because the non-SZZX postneonatal mortality rate did not change substantially during 1983-1989 and 1990-1994, a shift in diagnosis probably did not account for the larger declines in **SIDS** during 1990-1994. The occurrence of related diagnoses such as suffocation (ICD-9 code 913) and other ill-defined conditions (ICD-9 codes 780-797 and 799) increased from 1983-1989 to 1990-1994 (28.8% and 29.2%, respectively) (3), but these diagnoses combined comprise <1% of all infant deaths.

The Back to Sleep campaign should continue to publicize risk factors for **SIDS** and ensure that prevention messages reach **all** segments of the population, especially those at high risk for **SIDS**. In addition, widespread implementation of the recently published national guidelines for death scene investigation of sudden, unexplained infant deaths ( 10 ) should help standardize the investigation of these deaths and improve the accuracy of **SIDS** diagnoses.

[\*] Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

TABLE 1. Number of cases of and rate[\*] for sudden infant death syndrome[dagger], by race[section] and year -- United States, 1983-1994

| Year      | Black  |       |
|-----------|--------|-------|
|           | No.    | Rate  |
| 1983-1989 | 10,349 | 244.8 |
| 1983      | 1,518  | 269.8 |
| 1984      | 1,439  | 253.3 |
| 1985      | 1,357  | 233.2 |
| 1986      | 1,451  | 244.7 |
| 1987      | 1,447  | 236.8 |
| 1988      | 1,520  | 238.0 |
| 1989      | 1,617  | 240.2 |
| 1990-1994 | 7,315  | 219.3 |
| 1990      | 1,578  | 230.6 |
| 1991      | 1,589  | 232.8 |
| 1992      | 1,471  | 218.4 |
| 1993      | 1,442  | 218.9 |
| 1994      | 1,235  | 194.1 |

White

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1997 BILL ,

and, once licensed a person must meet standards for the operation of a licensed day care center established by DHFS by rule

Regen

1 AN ACT to amend 48.67 and 49.155 (Id) (a) of the statutes; relating to: requiring  
2 day care providers and employes and volunteers of day care providers who  
3 provide care and supervision for children to receive training in the prevention  
4 of sudden infant death syndrome.

the operation of a licensed

Analysis by the Legislative Reference Bureau

Under current law, no person may for compensation provide care and supervision for <sup>four</sup> or more children under the age of <sup>seven</sup> for less than 24 hours a day unless that person obtains a license to operate a day care center from the department of health and family services (DHFS). To obtain a license to operate a day care center, a person must meet the minimum requirements for the issuance of a license established by DHFS by rule. Also, under current law, a school board may establish and provide day care programs for children. A day care program established by a school board must meet the standards for licensed day care centers established by DHFS. In addition, under current law, a county department of human services or social services must certify a day care provider who is not required to be licensed by DHFS in order for the day care provider to be eligible for reimbursement for child care provided from child care subsidy funding provided under the Wisconsin works (W-2) program. To be certified as a day care provider under the W-2 program, a person must meet the minimum requirements for certification established by the department of workforce development (DWD) by rule.

by rule

in

plain

This bill requires DHFS, in establishing the minimum requirements for the issuance of licenses to day care centers that provide care and supervision for children

and, once certified, must meet standards for the operation of a certified day care provider established by DWD by rule



**BILL** most current medically accepted methods of preventing

licensees

under one year of age, to include a requirement that all ~~licensees~~ and all employes and volunteers of a licensee who provide care and supervision for children receive training in the prevention of sudden infant death syndrome. Similarly, the bill requires DWD, in establishing the requirements for certification of day care providers under the W-2 program, to include a requirement that all providers and and all employes and volunteers of a provider receive that training.

For further information *see* the **state and local** fiscal estimate, which will be printed as an appendix to this bill.

**The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:**

**SECTION 1.** 48.67 of the statutes as affected by 1997 Wisconsin Act 27 is amended to read:

**48.67 Rules governing child welfare agencies, day care centers, foster homes, treatment foster homes, group homes, shelter care facilities and county departments.** The department shall promulgate rules establishing minimum requirements for the issuance of licenses to, and establishing standards for the operation of, child welfare agencies, day care centers, foster homes, treatment foster homes, group homes, shelter care facilities and county departments. These rules shall be designed to protect and promote the health, safety and welfare of the children in the care of all licensees. The department shall consult with the department of commerce and the department of public instruction before promulgating these rules. In establishing: the minimum requirements for the issuance of licenses to day care centers that provide care and supervision for children under one year of age, the department shall include a requirement that all licensees who are individuals and all employes and volunteers of a licensee who provide care and supervision for children receive, before the date on which the license is issued or the employment or volunteer work commences, whichever is applicable, training in the prevention of sudden infant death syndrome.

most current medically accepted methods of preventing

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**BILL**

SECTION 2. 49.155 (Id) (a) of the statutes ~~was created by 1997 Wisconsin Act 27,~~

is amended to read:

49.155 (Id) (a) The department shall promulgate rules establishing standards for the certification of child care providers under s. 48.651. In establishing the requirements for certification under this paragraph of a child care provider who provides care and supervision for children under one year of age, the department shall include a requirement that all providers and all employes and volunteers of a provider who provide care and supervision for children receive, before the date on which the provider is certified or the employment or volunteer work commences, whichever is applicable, training in the prevention of sudden infant death syndrome. In establishing the requirements for certification as a Level II certified family day care provider, the department may not include a any other requirement for training for providers.

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**SUBMITTAL  
FORM**

**LEGISLATIVE REFERENCE BUREAU  
Legal Section Telephone: 266-3561  
5th Floor, 100 N. Hamilton Street**

The attached draft is submitted for your inspection. Please check each part carefully, proofread each word, and sign on the appropriate line(s) below.

**Date:** 2/22/99

To: Representative Kelso

**Relating to LRB drafting number:** LRB-2272

**Topic**

Child care; require providers to have training in the prevention of sudden infant death syndrome

**Subject(s)**

Children - day care

1. **JACKET** the draft for introduction Carol Kelso

in the **Senate** or the **Assembly** (check only one). Only the requester under whose name the drafting request is entered in the LRB's drafting records may authorize the draft to be submitted. Please allow one day for the preparation of the required copies.

2. **REDRAFT.** See the changes indicated or attached \_\_\_\_\_

A revised draft will be submitted for your approval with changes incorporated.

3. Obtain **FISCAL ESTIMATE NOW**, prior to introduction NO (ASK)

If the analysis indicates that a fiscal estimate is required because the proposal makes an appropriation or increases or decreases existing appropriations or state or general local government fiscal liability or revenues, you have the option to request the fiscal estimate prior to introduction. If you choose to introduce the proposal without the fiscal estimate, the fiscal estimate will be requested automatically upon introduction. It takes about 10 days to obtain a fiscal estimate. Requesting the fiscal estimate prior to introduction retains your flexibility for possible redrafting of the proposal.

If you have any questions regarding the above procedures, please call 266-3561. If you have any questions relating to the attached draft, please feel free to call me.

Gordon M. Malaise, Senior Legislative Attorney  
Telephone: (608) 266-9738

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