POISON CENTER
1-800-222-1222

Caring For Your Children

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NEWBORN CHILD AND ADOLESCENT MEDICINE
DIPLOMATES OF THE AMERICAN BOARD OF PEDIATRICS

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Plano, Texas 75093

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By Appointment

Office: (972) 596-2131

About Dr. McDonald

I attended Trinity University in San Antonio graduating with a degree in Physics and Biophysics and then enrolled in The University of Texas Southwestern Medical School in Dallas, Texas graduating in 1978. I stayed in Dallas to do a three year pediatric residency at Children's Medical Center and then went into a large private practice group initially, but founded Plano Pediatrics in 1988.

During my 36 year career I've helped over 7000 new parents and their newborns with practical advice when there's a problem and reassurance when things are fine. I've been selected as A Super Doctor by Texas Monthly Magazine, a Dallas Child Mom's Choice, a D Magazine Best Pediatrician and a Star Community Newspaper Best Pediatrician.

I've been Chief of Staff at both Medical City Plano Hospital and Medical City Lewisville Hospital and am currently President of the 600 member Patient Physician Network.

I founded Pediatrics After Hours, a pediatric evening and weekend urgent care, in 2007 which now has four locations across the Metroplex.

I been married to my wife Jeanne for 39 years and have three grown children: Meghan, who is an anesthesiologist at Zale Lipshy Hospital at The University of Texas Southwestern Medical School. Meghan and her husband Wayne, an oral surgeon, have twin two year old children, Claire and Archer.

Drew is a real estate attorney with Munsch Hardt. He and his wife Taryn, who is a health care attorney with Haynes and Boone, have a one year old daughter, Madison.

Ryan is working on a second Masters degree at The University of North Texas in Library and Information Sciences.

My greatest enjoyment has been watching babies, my children and grandchildren, become toddlers, go to school, go to college, become young married adults and bring their children back to me as their pediatrician. In pediatrics, you truly become one of the family.

About Dr. Katz

Originally from Chicago, I moved to Dallas in 1975 and attended St. Mark's Preparatory School. I graduated Cum Laude with a B.A. in Economics and Business Administration from Vanderbilt University and returned to Dallas to receive my M.D. from the University of Texas Southwestern Medical School in 1995. I then completed my three-year pediatric residency at Children's Medical Center in Dallas in 1998 and joined Dr. McDonald in practice at that time. In 2015, I completed an M.B.A. in Healthcare Management from the University of Texas at Dallas.

I have been married to Melissa since 1998 and have 2 sons, Jack (born in 2000) and Collin born in 2002). In my spare time I enjoy golf, skiing, reading, and especially my sons' sports and band.

I served as Chief of Pediatrics at the Medical Center of Plano in 2001, 2007 and from 2013-2016. I have served as the President of the 650+ member Plano Physicians Group since 2009, and have been a member of the clinical faculty at Children's Medical Center Dallas, the University of Texas Medical Branch at Galveston and the University of North Texas Health Science Center in Ft. Worth.

When Children's Medical Center of Dallas ventured into Population Health Management in 2012, I was hired to serve on the boards of their Clinically Integrated Network, Accountable Care Organization, Complex Care Medical Services Division and Dallas Physician Medical Services for Children. After helping them successfully launch their new initiatives, I resigned those positions in 2016 to focus on private practice and clinical research.

I have been voted the Best Pediatrician in Collin County 6 of the past 10 years, to D Magazine's list of the best pediatric specialists in Dallas, as well as to Texas Monthly Magazine's list of the best doctors in Texas every year since 2007.

Being a pediatrician has been a wonderful calling, and allows me to help parents shape their children's' futures.

About our Practice

Our philosophy is to assist you in the care of your children. We will provide regular physical exams and illness care. We will assist you and your children in the developmental process by suggesting readiness areas so that both you and your children learn to love and appreciate each other.

We hope that you carefully read this book provided to you for the care of your children. It gives you helpful information and guidelines for newborn and well-child health care. It also describes specific treatment for common, minor disorders, which can be instituted by you with complete assurance. Failure of the child to respond to these usual, simple treatment methods should alert you to call the office depending on the time of day. Our nurses are available for questions and phone calls. After hour medical advice calls are answered by a nurse answering service. We share call with other pediatricians in solo practice in Plano. The doctor on-call is available when an emergency arises.

Drs. McDonald, Katz	972-596-2131
Pediatrics After Hours	972-618-2493
Medical Center of Plano	972-596-6800
Police/Fire/Ambulance	911
Father's Work Phone	_____
Mother's Work Phone	_____

Neighbor's Name and Phone

_____

_____

Poison Control 1-800-222-1222

You may now visit us on the Internet at ***www.planopediatrics.com.***

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YOU AND YOUR PEDIATRICIAN

Care For Your Child:

It is the goal of your pediatrician to give the best possible care to your child by achieving and maintaining his physical and emotional well-being. It is important for you to learn how to use these services properly and to understand and recognize good pediatric care.

What Is a Pediatrician:

To become a qualified pediatrician, it is necessary to have three years of specialized training in children's diseases after completing medical school. To be board certified, a pediatrician must take a written examination. The American Board of Pediatrics now has a recertification program every seven years. It is of utmost importance we continue our education, so we will be attending medical meetings and post-graduate courses throughout the year. We care for children from birth to age 23 years. <u>We do not accept new patients over the age of 14 years.</u>

Office Hours:

Monday-Friday: 8:30 a.m. - 4:30 p.m.

Saturday: 8:30 am - 11:30 a.m. (When on Call)

Walk-in Clinic: Monday-Friday 8:00 a.m. – 8:45 a.m.

Emergencies:

Anytime you have an after-hours emergency which must be dealt with in less than one hour, go directly to the emergency room at the Children's Medical Center. For problems which can wait at least one hour go to an after-hours Pediatric clinic or, during office hours, please call the office and after hours, please call the office answering machine. Follow the taped instructions.

Phone Calls:

Ill child

If your child is ill and will need to be seen, please call at 8:30 AM. so we may schedule your child as soon as possible. If you are uncertain whether you need to have the doctor look at your child, please call at 8:30 and talk to the nurse, so she may advise you. Medical advice calls are prioritized and, therefore, are answered in order of age of child and urgency of problems. Please be patient during busy times. We receive 50-100 medical advice calls per day and delays may occur. **We return every medical advice call as soon as possible**.

Please try and limit after-hour calls and weekend calls to those you feel are absolutely necessary and cannot wait until regular office hours when your child's health records are readily available. Please have a pen, paper and your pharmacy phone number handy. Pediatric nurses are available 24 hours a day by calling the office number. We use a professional answering service to respond to your questions. IMPORTANT: Please notify us of any changes in address or telephone numbers. Whenever leaving town, make certain the person caring for your child has a notarized statement giving them authority to obtain medical care.

Hospital Privileges:

Although most of our hospitalized newborns and children are at Medical Center of Plano, we sometimes refer children needing specialized care to Medical City-Dallas or Children's Medical Center.

Office Visits:

1) **Health Maintenance Visit: A** time for evaluation of your child's physical and mental growth and development. This will involve history, physical examination, screening tests, counseling and immunizations when required. If you need extra time, please tell the receptionist. Please call well ahead of time (3 weeks to two months) to schedule a check-up. If you cannot keep the appointment, please be considerate enough to cancel the appointment well in advance. There is a charge for appointments not canceled.
2) **Sick child appointment:** Your child will be seen as soon as possible on the day you call. Call early in the day. If your child's condition worsens, call for an earlier appointment.
3) **Walk-in Clinic:** We have a walk-in clinic from 8:00am to 8:45am mornings M-F. It is for **sick children only,** no checkups or chronic problems

Things to Remember When Coming For an Office Visit:

(1) Come a short time before your scheduled appointment. (10 minutes).
(2) Have your questions written down. Some questions will be handled by our nurses.
(3) Be sure you understand our diagnosis and instructions for treatment.
(4) If you are asked to return your child for a follow-up visit, please do so to insure the original problem has been resolved. We'll both feel better.

Professional Fees:

Our goal is to give you the best possible medical care in the least expensive way. From time to time our fees will increase, related to inflation. If you ever have any questions, please talk to us or our office staff. Professional fees should be paid at time of service unless other arrangements are made.

Health Insurance:

It is customary to pay for services as they are rendered, unless other arrangements have been made in advance. We request you pay either by check or credit card at each office visit. All professional services rendered are charged to the patient. We look to you for payment. When you leave the office, please keep your receipt so you may file it with your insurance company for reimbursement.

Patients on PPO's or HMO's:

We are on numerous PPO's and HMO's. Please feel free to ask our front office staff if we have a contract with your current, or future insurance company. If we have a contract with your insurance company, we will file medical claims directly with your carrier. However, you must pay for co-pays, deductibles and non-covered services when you check out. We must have a current copy of your insurance card in order to file your medical claim. You must pay for all charges, if we do not have a copy of your current insurance card on file. Not all PPO's and HMO's provide the same coverage for preventative health visits (check-ups), immunizations or laboratory tests. You will be responsible for non-covered services. Please contact your insurance company to verify coverage on any specific items, if you have any questions. Some patients on HMO's and PPO's may have restrictions on seeing specialists without prior approval. The insurance plan may require use of specific laboratories, hospitals or x-ray facilities, if these services are necessary. Please contact our office or your insurance company before utilizing these services except in emergency situations. We will not retroactively authorize non-emergency use of these services. Our contract with your carrier, and your agreement with your insurance carrier, require both of us to follow certain procedures when accessing specialists or obtaining laboratory or x-ray services.

Nurse Practitioners:

Nurse practitioners are registered nurses who have a master's degree and advanced training in physical assessment, diagnosis, and treatment of children. They can write prescriptions and order diagnostic tests appropriate to the child's diagnosis. We will be available for immediate consultation should the nurse practitioner or you have any question during your child's appointment. At no time are you required to schedule an appointment with the nurse practitioner, but we hope you will avail yourself of her talents and time for both checkups and routine illnesses. If you have any questions, feel free to ask our staff or the physicians.

This booklet was prepared for you in order to help you help us better care for your child. Please take the time to review the booklet. If you have any questions, please ask. A good doctor patient (or parent) relationship is vital to good health for your child.

Office Policies and Procedures:

Over the years our office has developed policies and procedures to efficiently deal with many of the day to day issues that arise. We have found having established policies makes our interaction with you easier. However, none of these are "written in stone" and we would encourage you to discuss questions or problems regarding these policies with our office manager or the doctor.

1) There is a surcharge for any office visit, which was not scheduled in advance. This is in addition to the normal fees. This surcharge must be paid at the time of the visit and may or may not be covered by your insurance company. If one child has an appointment, but you decide you want other children examined who do not have an appointment, the surcharge will apply to all extra children seen. This surcharge also applies to all "walk in" visits for any reason. We are glad to see your children any time you feel they need to be seen, but it's impossible to have extra visits and stay on time. We encourage you to call ahead if you want your children seen.
2) All schools and camps for enrollment require immunization records. We encourage you to bring this reference guide with you to all "check ups" so we can record your baby's vaccinations.
3) Transfer of medical records sometimes is necessary because of moving or insurance changes. We will be glad to provide you copies after receiving a written request (required by law). If we have records from prior physicians in our chart, we will also forward those, if you specify their release in your request. All requests for medical records will be assessed a charge as specified by Texas Law.
4) Plano Pediatrics, P.A. has contracts with many different insurance companies. The physicians with whom we share calls may not be on all of the same contracts. If a covering physician in their office sees your child and they are not on your insurance plan, you must pay for all services provided at that time and then file your bill with your insurance company. We recommend attaching a note stating the visit was with a covering physician because we were closed and your child was ill. Your insurer should generally reimburse you.

5) Anonymous Call Blocking on your telephone at home has become increasingly popular. However, for privacy reasons, nurses and physicians returning your call may not he able to get through. Please remove call blocking if you are expecting a return call from our office.
6) Young children seem to be hungry and thirsty all the time, but please do not feed your children any foods after they are placed in the exam room. A drink of water, breast-feeding or bottle-feeding for children less than one year is fine.
7) Waiting for the doctor is certainly boring especially for children. We provide books and toys to help pass the time. Children should not run around the office, climb or stand on furniture or exam tables, throw toys, or write on the walls or furniture, or peel wallpaper. Please don't allow your child to do anything you wouldn't want done to your own home.
8) There is a charge for missed appointments not cancelled 24 hours in advance.

CARING FOR YOUR NEW BABY

This pamphlet is intended to acquaint you with your new baby, how to take care of your child, common newborn problems that might arise, and helpful hints on how to keep your baby healthy and happy. We will be happy to give you guidance and answer your questions while you arc in the hospital and later by phone and during your office visit.

Your baby should have his or her first medical checkups at 2 weeks and 8 weeks of age unless, of course, the baby needs our attention sooner. If your baby is discharged before 72 hours, we would like to check your baby in our office on day 3, 4, or *5* of life. This allows us to check the baby's weight, jaundice and answer any questions you might have. Please call our office for an appointment.

During this important first year, your baby should have regular medical examinations even though he or she appears well. These visits will give us an opportunity to check on your baby's growth and development and to talk with you about baby care and the many interesting things you can expect as your baby grows.

Getting To Know Your Baby

Sometimes new parents are somewhat unsure of themselves. However, as long as your baby is loved, well fed, warm, and comfortable, you need not worry that you are less than expert. The few simple infant-care instructions

that follow should help you to relax and enjoy your baby.
Your child is an individual from the day he or she is born. Each day you will discover more about your baby. Infant care is exciting and easy. Use your good judgment and common sense. Be aware and trust and accept your feelings. **Do NOT** strive for perfection. Be flexible and just enjoy your baby. Do not be afraid to make mistakes, you are capable and you will both learn together.
Your baby will do many of the things that all babies do. All babies sneeze, yawn, belch, and have hiccups. Giving the baby a few swallows of lukewarm water may stop hiccups. Crying is your baby's way of saying. "I'm wet, I'm thirsty, I want to turn over, I'm too hot, I'm too cold, I have a stomach ache, I'm bored, or I'm hungry." You will gradually learn to know what your baby means when he or she cries.

Sleeping

Research in many countries around the world shows your baby should sleep on his/her back. The increase of Sudden Infant Death Syndrome (SIDS) is 500% less in infants who sleep on their back compared with infants who sleep on their stomach. At approximately age 4 months your baby may begin to roll over. After that your baby may start on his/her back, but end up on his/her stomach. Don't worry; you've done all you can do.

Going Out/Travel

It is perfectly safe to take your baby out of the house immediately after birth for short trips, stroller rides and to church as long as the baby is dressed appropriately. However, we strongly recommend you avoid ill adults and children during the first two months of life. The only people more miserable than a baby with a bad cold or illness are the parents. Furthermore, infants under 2 months of age with fever are worrisome and require careful physical examination and laboratory evaluation in many cases.

It is ok to take your infant or young child on a car or airplane trip. There is no evidence of danger to your child during air travel. Many people recommend giving babies a bottle when taking off or landing, but this is only a reasonable idea and there is no proof it is necessary.

Colic

Almost all babies have fussy periods. These may occur regularly, perhaps in the late afternoon or evening. When babies cry for over an hour for no apparent reason, some people call this colic. Doctors don't know exactly

what causes colic, but theories include gas, constipation, “cramping colon”, nervous parents and mixed up days and nights. None of these theories explain all cases of colic.

There are many treatments for colic, none of which work all the time. The following ideas may he helpful. If you are breastfeeding, avoid all dairy products and caffeine. Milk in your diet is a common cause of the “colicky’’ infant. If you bottle feed, trying non-milk based formula such as ProSobee may help. If you try ProSobee for 10 days without improvement, a 7-10 day trial of special formula like Nutramigen may be indicated. Nutramigen is expensive, but well worth it, if it relieves crying. Other remedies include Mylicon drops (available without a prescription) 0.6 ml. 4 times per day for gas. If these ideas don’t help, let us know and we’ll work together to help you and the baby work through this difficult time. Remember:

1) It’s not your fault; babies with colic are born with this tendency.
2) All babies outgrow colic by age 2-3 months. Soon this will be a distant memory and you will have a healthy, happy, loving child.

Because your baby has not had time to build up resistance to infection, do the best you can to limit visitors during the first few weeks at home. Discourage friends and relatives from handling your baby, but if they insist, encourage careful hand washing.

Feeding

Care and regularity in feeding your baby will promote health and lay the foundation for eating habits for future years. Do not confuse the word regularity (meaning here simplicity and similarity) with schedules. Feeding schedules are not necessary, for either breast-fed or bottle-fed babies. Generally, your baby should be fed on a DEMAND SCHEDULE, or WHEN HE OR SHE IS HUNGRY. The demand schedule recognizes the infant’s own rhythms and allows him to eat whenever he chooses and the amount he chooses. Ultimately babies put themselves on a fairly regular schedule. The demand schedule produces happier, more secure infants and more relaxed parents.

Both of you should he comfortable. You should have a comfortable chair and the baby should be warm and dry. Bottle fed babies will take 2-5 ounces every 2-4 **hours.** We generally recommend waking infants every 2-3 hours during the day, but allow the baby to sleep as long as he/she wishes at night.

Breast Feeding.

Breast milk is an ideal Food for infants: it is the most natural primary **f**ood substance your child can have and, as the mother produces it, it is certainly the simplest form of feeding. Nurse your baby if at all possible: more is imparted to the child than just milk. There are many psychological rewards for both mother and child through nursing, such as intimacy and warmth. Breast-fed babies have enhanced immunity to common respiratory and intestinal infections. Breast milk may not come in fully for the first 4 to 5 days. A well-rested mother with a well-balanced diet, with strong emphasis on good nutrition and all the proper vitamins and minerals and an adequate fluid intake will produce adequate milk, as well as maintain her own good health. A note of caution; inform the doctor of any drugs or medications you may be taking, as these may pass through your breast milk to your baby.

If you do breast feed your baby, wash your hands and breasts before feeding. Guide the nipple into the baby's mouth. At the same time, take care to keep the breast from pressing against the baby's nose to interfere with his breathing. Gently stroke the infant's cheek nearest your breast: he will then turn his head to search for the nipple.

Your baby may nurse from both breasts at each feeding. Make sure each breast is emptied before moving baby to the other; 10-15 minutes at each breast is usually long enough. However, if preferred and if your milk supply is good, only one breast need be used. You should alternate the breast on which you start. If your baby is very active in his nursing, allow him to feed at only one breast and give the other breast a rest period. Your baby will nurse every 2-4 hours.

Your baby will take most of your milk in the first few minutes of each nursing. Therefore, the baby should not be permitted to nurse longer than 20-30 minutes at any one time (10-15 minutes/breast). In the first few weeks, while you and your baby are learning, let him have a little more time if he needs it. For your comfort and relief, a feeding of the formula that we prescribe may be substituted occasionally for a breast-feeding. <u>Your baby does not need extra water for proper nutrition or satiety</u>.

We are fortunate to have a Pediatric Nurse Practitioners who is a Certified Breastfeeding Educator. If you are having breastfeeding problems, please call our office and schedule a 30-minute consultation with our Nurse Practitioner to help you and your baby breastfeed. Try to have your baby hungry when you come.

Tips for Breast Feeding in the Hospital

1. Breast-feed as soon as possible in the delivery room. The RN will be able to assist you as needed.
2. Breast fed babies like to eat often and should be fed when the first signs of hunger are noticed, such as crying, rooting, or vigorous sucking on the hands. This may be every 1.5 hours to every 3 hours. A newborn needs to be nursed at least every 3 hours. Your milk may not come in for 2-4 days, but your baby will be getting nourishment through your colostrum. Two or three wet diapers a day, until your milk comes in, is a good sign that he/she is getting enough to eat.
3. You are the best source of milk for your infant. Your baby needs to learn to suck from your nipples (not a bottle), and your nipples need to get used to your baby. Breast-feeding can be uncomfortable in the beginning but it soon eases. Lanolin ointment can soothe sore nipples and is available in the hospital and the drug store. Any severe pain should be discussed with a medical professional.
4. A breast pump should not be used in the first few weeks unless ordered by the pediatrician.
5. Pacifiers should be used minimally until breast-feeding is successfully achieved.
6. Bottles of sugar water or formula should not be given to a breast fed baby unless ordered by the pediatrician. Bottles can hinder successful breastfeeding. However, occasionally they are needed, if ordered by the physician for medical reasons. They may also be used occasionally, if the mother needs a few hours break and some sleep.
7. A breastfeeding class may be offered either prenatally or at discharge. We encourage you to attend this class as many of your initial questions can be answered.
8. Family support of breastfeeding is very important to successful breastfeeding. Dads, grandparents, and other family members are asked to support and encourage the nursing mother.
9. Breast milk is supply and demand: the more the infant nurses (demand) the more milk your body will make (supply). While in the hospital it is important that you practice breast-feeding at every opportunity. Therefore, your baby will be brought to you to nurse during the day and night unless you request otherwise.
10. You may ask for breastfeeding help around the clock from a nursery nurse or lactation consultant while in the hospital. After you are

discharged, you can also call our office during office hours. Non-emergency after-hours calls will be returned the next day.

11. We encourage you to continue your prenatal vitamins as long as you are nursing.
12. Besides health care professionals, other breastfeeding moms are a wonderful source of help, advice, and encouragement.
13. How long you choose to breast-feed is up to you. Most infants will self-wean around 1 year when table foods are introduced. When you choose to wean, it is usually easiest on mom and baby to do so gradually.

Bottle Feeding

Some mothers simply do not wish to breast-feed. Today's infant formulas are excellent and complete foods for the first 6 months of life. Seated comfortably and holding the baby, hold the bottle so that the neck of the bottle and the nipple are always filled with formula. This helps your baby get formula instead of sucking and swallowing air. If he doesn't waste energy sucking air, he's more likely to take enough formula. Air in his stomach may give a false sense of being full and may also make him uncomfortable. Your baby has a strong, natural desire to suck. For him sucking is part of the pleasure of feeding time. Babies will keep sucking on nipples even after they have collapsed. So take the nipple out of the baby's mouth occasionally to keep the nipple from collapsing. This makes it easier for him to suck, and lets him rest a bit.

Never prop the bottle and leave baby to feed himself. The bottle can easily slip into the wrong position. Remember your baby needs the security and pleasure it gives him to be held at feeding time. It's a time for your baby and you to relax and enjoy each other. Never use a bottle as a night or naptime pacifier. The milk is converted by the baby's saliva into a weak acid that can damage tooth enamel. Please do not put the baby into the crib with a bottle. Your baby does not routinely need extra water, if formula fed. Your baby should be off the bottle totally by age 12-13 months. We have seen many children with severe cavities involving the top 4 teeth, necessitating dental work and even capping, who were on the bottle past 12-15 months. We have seen only 1 child in over 32 years with dental problems from the bottle, who was off the bottle by age 15 months.

Formula Preparation

Use Ready-To-Use liquid Enfamil, Similac or Good Start

Concentrated Formula (1ounce formula to 1 ounce water)

OR Powder (1 scoop of powder to 2 ounces of water)

Follow instruction on the container unless told to do otherwise.

NEVER MAKE FORMULA STRONGER THAN PRESCRIBED

Usually a 24-hour supply of formula can be prepared at one time, but an extra bottle or two may be added to use up a can of formula. If refrigeration is good, any amount up to a 48-hour supply can be prepared safely or an open can of liquid formula can be safely stored in the refrigerator.

Burping

Burping your baby helps remove swallowed air. Burp or bubble him by holding him upright over your shoulder, and patting his back gently. Or place him face down over your lap and gently rub his back. He can also be burped by holding him in a sitting position (baby leaning slightly forward) on your lap, with your hand supporting his stomach. **Gentle** bouncing may help in this position. Breast-fed infants usually don't burp as much as bottle-fed infants.

Water

Your baby does not need water for proper nutrition. However, a few sips of water may alleviate hiccups and 4 ounces on a daily basis may help constipation. **Do NOT** use honey.

Spitting Up

Many normal babies spit up frequently. This is because babies have a weak "valve" between their stomach and esophagus (the tube leading to the mouth). This valve tends to tighten after the first year of life. Spitting up is normal unless your child has repeated "projectile" vomiting (extremely forceful), or if your baby is failing to gain weight. Spitting up is decreased by sitting the baby upright for 30 minutes after feedings and by thickening formula with rice cereal (1 tablespoon per 4 oz. formula). Call us if symptoms persist or worsen.

Keeping Utensils Clean

All utensils used in preparing formula must be clean. Scrub bottles, nipples and caps with hot, soapy water and a bottle brush, squeezing water through holes in nipples. A detergent removes scum better than soap. Rinse well with hot water. Protect bottles by putting them upside down on a rack or clean towel. Put nipples and caps in a clean jar. Saucepan, measuring pitcher, can opener and other articles used should be washed and rinsed, and kept

protected until time to use them. Automatic dishwashers are fine for bottles as well. Boiling bottles and nipples is unnecessary.

Test Nipples Regularly

Nipple holes should be the right size to help your baby suck easily. When nipple holes are the right size, milk should drip as rapidly as possible without forming a stream. If nipple holes are too small, baby may tire of sucking before he gets all the formula he needs. If holes are too large, he gets too much formula too fast and may not get enough sucking to satisfy. He may also choke or gag. If nipple holes are too large, the nipple is worn out and should be thrown away. Enlarge too-small holes by pushing a red-hot needle through them.

Baby Foods

There is no set time when a baby will need to begin with foods. In general, the later the better. Solid foods are not necessary until age 4-6 months. Most breast-fed babies are completely satisfied with only the breast until 6 months. In general bottle babies will want foods somewhat earlier.

At approximately age 4 months you may start rice cereal, either with flakes mixed with formula or breast milk, or a ready to feed (usually with applesauce or banana added). Start with 1-2 tablespoon(s) per feeding and increase as your baby's appetite increases. There is no correct amount. After you have fed your baby rice cereal successfully, you may do the other cereals (barley, mixed) - and then start vegetables, fruits and meats. Add a new food every two days. Feel free to stop any foods your baby doesn't like or seem to have a reaction to after eating. Most people add meats last after 9 months.

Your baby should gradually increase to three feedings per day by age 6-9 months. You may see some decrease in formula intake and this is fine as long as the formula volume taken is over 26 oz. at 4 months, 22 oz. at 6 months and 16 oz. at 9 months per 24-hour period. Breast-fed babies may slightly decrease their feedings, but don't worry unless it interferes with your milk production in the first 6-7 months. After that, your baby may normally breast feed less. You may start 2nd foods after your baby has taken all the first foods. Second and 3rd foods are generally mixtures of foods and less pureed (more textured) and some babies like the change, others don't. Advance your baby, as he/she is ready.

Most children are ready for finger foods (toast, bagels, wafer cookie, zwieback toast, etc.) after age 6 months, but we don't recommend small finger foods until age 9 -12 months. Most children start some table foods age 9 -12 months and switch totally by age 12 -15 months.

Your baby may start water in the cup at age 6 months. We recommend use of a training cup. Limit your child's juice intake.

INTRODUCTION OF SOLID FOODS

In general, solid foods are a supplement to and not a replacement for breast milk or formula. They should be given after or separately from a breast or bottle-feeding. They should not cut down the intake of milk a baby takes until the child is 8-12 months old.

Several general principles:

1. Generally solids are started about age 4-6 months. (See #5 below). Breast-fed babies generally start solids closer to 6 months if mom and infant are satisfied, but may start after 4 months, if the infant is hungry.
2. You introduce a new food every 2-3 days so that if the baby reacts to the food with vomiting, diarrhea, rash, etc., you know which food it is. Example:
   carrots Monday, Tuesday; Squash - Wednesday & Thursday. After all foods are introduced, you can mix and match.
3. Babies have likes and dislikes and if they don't like a particular solid, such as green beans, simply drop it from the menu. There is no solid that a baby has to have.
4. The serving size per solid is roughly half a jar, which is two ounces or a fourth of a cup. However, you should generally feed your baby until full.
5. Before 4 months of age it may be appropriate to sometimes add cereal to formula (2 tablespoons per 4oz. formula). After 4 months, infants should be fed with a spoon: never use an infant feeder.
6. Introduce foods as follows:

   Cereal: Rice, then Oats, Barley and Mixed.

   Fruits: Introduce these in any order.

   Vegetables: a) Yellow vegetables - such as squash, carrots, etc.

   b) Green vegetables - such as peas, green beans, etc.

Meats: Any order. Meats are the least favorite food of many babies so do not be alarmed if your infant does not eat very much.

Most babies will eat 1-2 solid meals per day starting at age 4-6 months. As they grow older this generally increases to 3 feedings per day. There is no "right' time or amount to feed your baby. You and your baby should

establish a routine that **is** best for the both **of** you. There is no "right" way to feed cereals, fruits, vegetables and meats. Most parents feed their infants like they feed themselves i.e., cereal and fruit in the morning, vegetable and fruit at lunch, vegetable + meat + fruit for dinner. However, any system is okay as long as it is reasonably well balanced. Our children ate cereal + fruit at all 3 meals and had vegetables and meats at lunch and dinner.

FEEDING YOUR TODDLER

Your baby has now entered the exciting and ever-changing world of the toddler. As a parent, this tune is both frustrating and rewarding, putting your parenting skills to the test continuously.

The toddler stage has many challenges: independence, development of language, weaning from the breast/bottle to a cup, slumping appetite, the development of food jags, temper tantrums and learning to eat with a spoon. The decrease in the toddlers' appetite during the second year of life is very disturbing to most parents. However, this appetite slump is quite normal. The growth rate of the toddler is much slower than that of the infant; therefore, the toddler's calorie requirements are also decreased. Now that the toddler is no longer taking a bottle and prefers to feed himself/herself parents are faced with another challenge: what do you feed a toddler?

SUGGESTED FINGER FOODS APPROPRIATE FOR BABIES 1 YEAR AND OLDER

VEGETABLES

Cauliflower
Cherry tomatoes (halved)
Tomatoes, peeled
Mushrooms
Lettuce, cut up
Avocado, ripe
Asparagus tips
Broccoli tips
Green beans
Cooked sweet potato
Mashed potatoes
French fries
Peas
Pickle spears
Carrots, cooked

FRUIT

Apples, peeled
Pears, peeled
Peaches, peeled
Navel oranges, peeled & sectioned
Mandarin oranges, canned
Fruit cocktail, canned, lite syrup
Fresh berries
- Strawberries, halved
- Grapes, halved, seedless
- Sweet cherries, pitted
- Blueberries

Watermelon, pitted & cut into bite-size pieces
Cantaloupe, cut into bite-size pieces
Banana, whole or cut into thirds
Dried fruits

DAIRY

Small squares of soft cheese, American, Gouda etc.
Cottage cheese (add fruit, fresh or canned, for interest)
Yogurt (may be served semi frozen)

MEATS

Small meatballs
Tender roasts (may grind)
Hamburger (try different shapes. such as sticks)
Lamb chops (without bone)

Veal
Chicken or turkey, diced
Ground turkey cooked like hamburger
Chicken or beef liver
Tuna fish
Spare ribs, well cooked
Ham cut into bite-sized pieces
Luncheon meats
Sausage
Fish without bones
Beans, soft cooked (½ cup beans is equal to 1 meat substitute)

BREADS AND CEREALS

Lightly buttered toast, cut into fourths
Saltines
Pretzel rods
Graham crackers
Cold cereals (dry or with milk) avoid those that are sugar-coated, honey-coated, or chocolate flavored.
Sandwiches broken into small pieces
Arrowroot cookies
Zwieback
Triscuits
Oyster crackers
Bagel and cream cheese
Hot cereals
Cooked macaroni
Cooked spaghetti
Spinach noodles

WATCH OUT FOR THESE FOODS!!!

Because they may cause your baby to CHOKE, the following foods should he avoided. They may he safely introduced after your baby is 4 years old.

NUTS, CHIPS, FRUITS WITH SEEDS, POPCORN, CELERY, RAW

CARROTS, FISH WITH BONES, TOUGH MEAT, SMALL OR HARD CANDIES, BACON, FRANKFURTERS, BEEF JERKY.

Because they may replace more nutritious foods and encourage a sweet tooth:

COOKIES, PASTRY, SUGARCOATED CEREALS, CANDY, KOOL-AID, CAKE, SOFT DRINKS, BEER, CANDY FLAVORED FRUIT DRINKS.

Because they are hard to digest:

BACON, SAUSAGE. FATTY OR FRIED FOODS, HIGHLY SPICED FOODS, WHOLE KERNEL CORN.

Because it can cause botulism in the baby under one year of age:

HONEY

Vitamins

Vitamins are recommended for breast fed infants starting in the first few days. If you wish to provide extra vitamins to be sure of proper nutrition, Poly-Vi-Sol is a good choice. Formula fed babies do not need vitamins unless premature or if taking less than 1 quart of formula daily.

□ Poly-Vi-Sol with iron drops □ Tri-Vi-Sol with Iron Drops (Breast Fed Only) Dosage: one dropper daily.

When you give vitamin drops, fill the dropper to the FULL mark. Place the dropper between your baby's gums and cheek almost halfway back in the mouth, and slowly squeeze out contents.

Iron

All babies need iron for the formation of red blood cells. Low iron formulas are never appropriate. We recommend all children stay on vitamins with iron after they go off the breast or formula.

General Baby Care

Washing the baby. It's good to have a fairly regular time for bathing your baby. The room should be warm, with no drafts. Keep bathing supplies together to save you extra steps. Until the navel (and circumcision) heals, do not give the baby a full bath, but wash by sponging. After healing you can use a tub or bassinette. When you wash the baby, wash really well, getting into all the creases and folds.

Face. Wash with water and soft cloth. (If soap is used, be careful not to get it in the baby's eyes.)

Eyes. To clean eyes, use a cotton ball or a washcloth dipped in cool water.

Nose and ears. Clean outer areas only with a moist washcloth or cotton ball. Do not attempt to clean the inside of either the nose or ears.

Mouth. Do not cleanse inside.

Head. Baby's head should be lathered gently (work from front to back to keep soap out of eyes.) Do not hesitate to rub the scalp overlying the soft spot.

Body. Use a mild soap such as Dove and wash and rinse well. Be sure to wash in the creases.

Skin Protection. Use as little lotion as possible and only if the baby's skin is exceedingly dry. Avoid excess in the creases. Baby lotion is not recommended: instead try eucerin or aquaphor.

Skin Rashes. Use Desitin ointment for diaper rashes unless otherwise indicated. Generally no creams or powders are needed on the baby's bottom.

Navel. Keep it clean and dry. Do this until the cord is completely healed. Sometimes after the cord falls off there may be a few drops of blood. The cord will fall off in 7 to 14 days. It is ok to give your baby a bath before the umbilical cord falls off, but put sure to dry the area thoroughly afterwards Please call the office if the umbilical cord has not fallen off by age 4 weeks.

Circumcision. Circumcision has been customary in the United States (not in many other countries) since the 1920's. In the past the procedure was one without discussion or consent. Now parents must make an "informed decision". It appears uncircumcised infants have a slightly higher risk of urinary tract infections, local skin infections around the penis and penile cancer. Circumcised boys have a risk of bleeding and infection following the procedure and, of course, the pain of the procedure. If the mother or father desires the procedure, it should be done in the nursery unless culture or religion dictates otherwise.

Care of the diaper area. Change your baby's diaper as soon as possible after each bowel movement or urination. Always change before feeding so that the baby is dry and comfortable while eating. After each bowel movement and as often as you can after urination, clean the diaper area. Water is fine, pre-moistened wipes are also useful. Keeping a baby's bottom clean and changed will prevent most diaper rashes and cure most of the ones that do occur.

Room Temperature. Try to keep an even temperature in the baby's room. On hot days provide sufficient ventilation to prevent the room from feeling stuffy. On cold days, check your baby occasionally to see that he's covered enough to be warm and comfortable, and that there are no drafts. The house

should be kept at a temperature that is also comfortable for other members of the family, usually 68-78º.

Bassinet or Bed. The baby's crib mattress should be firm and flat. No pillow should be used. Protect the mattress with a waterproof cover.

Clothing. Your baby does not require any more clothing than an adult, so never overdress him. Dress him according to the temperature and what you would wear yourself.

Outdoors. A fairly good rule to follow is to take your baby out whenever the weather is pleasant. Babies born in summertime may be taken out on a nice day after they are 1 week old, as weather permits.

Sun Block. All children need sun block with an SPF of at least 45 applied anytime they are going to be outside for more than 15 minutes. Dermatologists have assured us it is safe to use sun block on young infants under 6 months of age. Apply the sun block about 30 minutes before going outside, and reapply frequently, especially if it is not "waterproof", but at least every 2 hours when out for prolonged periods.

KISS. (Kids in Safe Seats) It is mandatory that all infants ride in a suitable car seat beginning with their first ride home from the hospital. Children over 40 pounds must always ride in a seat belt positioning booster. Choose a safety-approved seat, one chosen according to the weight and age of the child. A properly used restraint affords your child at least 90% protection.

We will be happy to provide a prescription for a safety seat. Generally infants should face backward in an infant seat until at least 24 months and as long as they still properly fit in a rear-facing seat. Nowadays, many infant seats are designed to hold children up to 40 pounds in the rear facing position. Before that their head control is insufficient to face forward, which is dangerous should a sudden stop occur.

General Development Record

1st Month. Head needs support. Hands tightly fisted. Eyes do not focus and may even seem crossed. Hearing is fully developed. Yawns frequently, hiccups, sneezes. Main occupations are sleeping and eating.

2nd Month. Becomes adjusted and establishes a fairly regular routine. Turns head toward sounds. May lift up head when lying on the stomach. Cries become distinguishable for hunger or discomfort, quiets when picked up. Child begins to see mobiles. Squeals and laughs.

3rd Month. Enjoys bright colors and toys. Can turn from side to side. Holds up head. Tries to coo. Has learned that crying gets a response. Smiles. May

lunge forward in infant seat, so do not place infant in seat on countertops after 3 months of age.

4th Month. Plays with hands and can hold toy in hand. Reaches with hands, may play with feet. Eyes have focused. Coos and laughs in response to others. May roll over so safety becomes important. Teething and drooling may start.

5th Month. Tries to put things in mouth. Holds up arms to be lifted. Turns himself from back to side. Begins to show more definite likes and dislikes for certain foods.

6 to 9 Months. Learns to sit alone. Rolls over both ways. Eyes are controlled. Can pick up objects. Teeth may begin to appear. Likes baths and water play. Strangers may annoy. May link words with ideas. Passes objects from hand to hand.

9 to 12 Months. May have 6-8 teeth. Understands words and tries to imitate speech and activities of family. Creeps. Learns to stand. May start to walk, or may walk alone.

12 to 18 Months. Child can recognize some body parts. Walks, runs, and climbs. May walk up steps. Again, safety becomes a factor in child's care. Has 12 teeth. Uses single words and occasional phrases. Learns to care for self, e.g. brushes teeth, may remove clothing, washes hands. Uses a spoon.

24 to 30 Months. May begin to toilet train or have an awareness of it. Has 20 teeth. Uses sentences. Knows whole name. Throws a ball. Recognizes many body parts. Starts to pedal a tricycle.

Common Symptoms and Illnesses in *The First Month*

Fever

Any axillary (under the arm) temperature over 100.4° in the first four weeks of life should be called to our attention immediately. (See next section for infants over 1 month.)

Vomiting

Normally babies will tend to spit up; this is just mouthfuls at a time. Projectile vomiting may occur due to over feeding or too much air, but if it occurs on successive feedings, let us know. (See next section for infants over 1 month.)

Diaper Rash

There are two basic types of rash seen in the first month. A scald or burn type rash can occur secondary to stool or urine. This can be treated with very frequent changing and application of a diaper ointment. The other type is due to yeast, which produces small bumps. Yeast infections can be treated

with clotrimazole cream applied three (3) times per day to the diaper area for one week. You may purchase clotrimazole at the pharmacy without a prescription. The other general area of rash is on the face and body. This usually consists of small red bumps (heat like). This is common and will come and go - no special treatment is needed.

Jaundice

Jaundice is a term describing the yellow color in the skin and eyes, which infants develop with a high bilirubin level. Bilirubin is a substance, released by red blood cells, which is broken down in the liver and excreted in the stool. Many babies become jaundiced because of a high red blood cell count, which releases lots of bilirubin, that their immature livers don't break down fast enough in the first week. This may be exacerbated by blood incompatibility between the mother and infant, extensive bruising, prematurity and breast-feeding. Most infants never reach a "high" (over 18) level of jaundice and require no treatment. Sometimes infants will reach a "moderate" (12-16) level of jaundice and need their bilirubin checked. A few of these babies will reach a level of jaundice, which requires phototherapy for a few days. Very rarely babies will need blood exchanges or "exchange transfusions".

In general, jaundiced babies need no special treatment. They need no supplemental water, but it is helpful to feed (breast or bottle) the infant frequently. Occasionally a breast-fed baby may need to stop nursing for 24 hours and substitute formula, but this is only if the bilirubin reaches a "high" (over 18) level. It is important to realize that jaundice is usually a "well baby" problem and of minimal concern. Only babies who are ill or reach high levels of bilirubin require special treatment. We are able to quickly check your baby's bilirubin in the office. Call if you think your child is yellow or jaundiced.

Eyes

For the first week the eyes may be swollen with some drainage. After this time, if there is still drainage, call.

Thrush

If white spots inside the mouth persist, call the office. They may look like milk curds but will not rub off. This indicates thrush, which is a yeast infection of the mouth.

Colds

Infants are susceptible to colds. They usually start as nasal congestion followed by discharge. If there is no fever, use a vaporizer, nasal aspirator (small ear syringe works best) and saline nose drops (¼ tsp. salt to 4 ounces of water). Simple nasal stuffiness is probably not a cold, but just a small

nasal passage. This can be aggravated by dry air in the home, especially in winter with heating.

Sleep

Infants

The newborn infant usually sleeps from 15-17 hours per day during the first 4-6 weeks of life. By one year of age, total sleep time has gradually diminished to approximately 12-16 hours. Until 15 months, the baby naps on the average of twice a day; from 15 months to 3 years usually once a day, and the older child only naps occasionally thereafter.

He may awaken every 2-5 hours for feedings, activity, a diaper change and then go back to sleep. Wakeful periods become progressively longer as the infant grows older. Schedules vary and change often with individual infants. Some infants sleep through the night by the age of 12 to 18 weeks; however, they may normally continue to awaken for a 2 A.M. feeding. Remember, however, that infants sleep through the night only after their nervous systems become mature enough.

If your infant cries when put down for sleep, remember that no harm will be done and that the crying will soon stop. After 8 weeks, 10 minutes of crying is acceptable.

Older Children and Bedtime Routines

There is no way to maintain a regular sleeping schedule for a child, but it is important to try to have a reasonably consistent bedtime routine. Often such things as illness, vacations, visitors and other extenuating circumstances will interfere with the bedtime routine. However, there are a few generalizations that can be made which will often clarify bedtime habits and relieve bedtime tension. Most children between the ages of 18-36 months seem to accept bedtime better if they have some type of routine or ritualistic activity before getting into bed. An example of this is the child who gets ready for bed by putting on his or her pajamas, emptying the bladder, brushing the teeth, and listening to a story, song, etc.

The child who fights going to sleep should get up in the morning at the usual time regardless of the hour they fall asleep, thus they become responsible for the consequences of their nighttime activity. In general, children should not routinely sleep with their parents because this may become a habit that is difficult to break and there is an increased risk of suffocation.

Teething

There are many signs and symptoms that have been attributed to teething such as: nighttime restlessness, increased finger sucking, drooling, gum rubbing, loss of appetite, change in bowel habits, colic, colds, earaches, and fever. It is difficult to know if teething causes their minor complaints. However, symptoms such as fever over 101 degrees, vomiting, repeated loose stools or severe cough are not due to teething and, if persistent, should trigger a call to the office. Start brushing or wiping teeth with a washcloth without toothpaste as soon as teeth appear. Children should start using a toothbrush with either no or very minimal fluoridated toothpaste at age one year. Children should have their teeth brushed by their parents at least once daily until they are old enough to do a thorough job with supervision. Children swallow toothpaste so its use should be kept to a minimum. Many experts recommend withholding fluoridated dentifrices (mouthwashes) until after 2 years old. Many pediatric dentists recommend seeing children between ages three (3) and four (4) years, sooner if problems are suspected.

Teething Aids

When the parents find that their child is actually cutting teeth, you may offer the following aids to the child; ice or popsicles for chewing and numbing of the gums, semi-hard objects such as teething rings so that the child himself will help facilitate the cutting of the tooth. Tylenol, or Ibuprofen may also be given (Sec dosage chart on pages 30-31).

Toilet Training: Wait Until the Child is Ready

The task of toilet training seems to occupy a great deal of thinking of most young parents. It is relatively easy to accomplish if it is put in the proper perspective and if the parents' preoccupation with success is not transmitted to the child. The most important advice is to wait until the child is both physically and psychologically ready and willing to be trained. Toilet training is then best accomplished by allowing the child to develop good bladder and bowel habits at his own pace. The nerve development and control of both the bladder and bowel progresses so that first the child learns to retain stool and urine and only later does he learn to spontaneously release them. The latter is usually accomplished by 24 months of age. Any attempt at toilet training should always be pleasant and relaxed. It should be started when the child expresses readiness and interest. Early success does not indicate a "good mother" or a "good child," but it does represent a child who is ready to be trained. Force should never be used in an attempt to teach toilet training. "Breaking" a child suggests force and is definitely a mistake.

Most children are physically ready to toilet train by age 24 months, but may not psychologically be interested until age 24-30 months for girls and 30-42 months for boys (boys tend to be less interested and more stubborn). Most children toilet train for voiding first, but toilet training of stool may be much later, so don't worry. Continuing to use a diaper is ok, if necessary.

Beginning Toilet Training

Timing is extremely important and parents will be able to judge when their child is ready to train. This is between 18-24 months and usually closer to 24 months. Sometime after the age of 18 months one begins to introduce the child to either the 'potty chair' or "potty seat" as his/her very own, and to become familiar with it by sitting on it while still wearing clothes. The child should never be forced to use it if he shows no interest. If rebellion occurs, stop all activity for the time and begin again at a later date. Next the child uses the chair or seat without clothes or diaper. During this period, teach him to communicate to you about the activity taking place. This is especially true when you are changing the baby's clothes after a failure or as they follow you to the bathroom where they are made familiar with the process. Learning by example and demonstration, by explanations and experience, are methods used to teach your children toilet training at this time. Success slowly follows. The children should be rewarded with a kind word of praise. They should, however, never be scolded, ridiculed or punished for failures.

Nap and night training gradually follow and normally are not problems, if the toilet has been handled properly in the beginning. Many children, especially boys, will wet the bed at night, long after they are toilet trained during the day. This is normal.

Discipline

Discipline is one of the most difficult areas encountered in raising a family. Parents soon discover that there is no single correct way to discipline their children. As each child (and each parent) is an individual, what works for one child and parent may not work for another. In addition parents react differently to each of their children, changing their attitudes toward disciplinary problems as they, their children, and the problems develop.

Learn To Communicate Together

The key words associated with good discipline are consistency and communication. Children quickly learn how to play one parent against the other. If discipline is to be effective, parents must learn to "stick together," even though they do not always agree. Thus the differences (or inconsistencies) that exist between parents must always be worked out privately or away from the children. Consistency in discipline must always include reasonable judgment; the punishment must always fit the crime.

Children always recognize fairness, so when we do make mistakes in discipline, an honest apology goes a long way toward a good open child-parent relationship. Communication is the heart of good family unity, especially if children know that parents are willing to listen with an open mind. Under such circumstances, compromises amongst all parties often occur although, initially, there may have been great areas of disagreement.

Types of Discipline

There are many ways to discipline children on inappropriate behavior or actions. Currently most physicians or counselors recommend "time out" for younger children. Time out should generally be for 10-15 minutes in younger children, but the length may he increased for older children. The "time out" area may be a quiet area of the house away from other children. The child should be clearly instructed on the length of time being used and the inappropriate behavior being corrected.

As children grow, negative or positive reinforcement is helpful. In negative reinforcement, the child has privileges, treats, etc. removed for inappropriate behavior. In positive reinforcement, special rewards or treats are awarded in recognition of appropriate behavior.

In all types of discipline, it is important both parents have agreed on what is acceptable and unacceptable behavior. When inappropriate behavior occurs, it must be consistently punished. Conversely, appropriate behavior should be rewarded with a word of praise. Children are easily confused if punishment is not consistent.

Parents commonly ask us about corporal punishment (spanking). We feel corporal punishment has a very limited role in discipline and have not found it very effective with our own children. Corporal punishment may be a way of adding emphasis to punishment techniques, mentioned previously. It should never be done in anger or in sufficient force to injure the child. Other forms of punishment, if used consistently, will generally be effective without the use of corporal punishment.

Isolation (as a method of discipline)

After the first year, a child will frequently modify unwanted behaviors if told "when you behave this way, you will have to spend some time away from us." The child then may be isolated for 5-10 minutes.

Adolescence

Every family has its own way to deal with disciplinary problems, and this is especially true with adolescents who seem to put a severe strain on their parents because of their continual struggle for independence. Teenagers are

trying to find out who they are and where they are going as they grow apart from the family. This struggle within the family can be a frightening experience for both the "child-adult" and the parents. When shedding childhood dependence, children seem to be purposely trying to disagree with family views. Understanding this situation and choosing the proper discipline may not be easy, but this is a time when children really need our love, guidance and tolerance. Do not be afraid to seek professional help, if things seem to be getting out of control.

COMMON CHILDHOOD DISEASES

1. Fever

What is fever? Fever, the elevation of temperature above normal (98.6°F) creates more anxiety in parents than any other symptom associated with disease. It is one of the body's weapons against infection. Therefore, fever is a helpful symptom, and it becomes apparent that we may do the patient an injustice by over-enthusiastic attempts to reduce the temperature.

Fever serves as an indicator of the progress of disease. Fever does NOT cause brain damage of and by itself. Look at the whole child: what is his behavior, appetite, activity, etc. We recommend you take a child's temperature under the arm, leaving the thermometer in place for 4 minutes. The new tympanic "ear" thermometers are not reliable in children under 10 years and should not be used.

Treatment

Non-specific measures (sponge baths, Tylenol or substitutes, and light clothing) employed to treat fever may be used before contacting us, because elevations of temperature are common and maybe short-lived in infants and children. As a general rule, if an infant of two months or less has a fever of 100.5 degrees or more rectally, we should be contacted.

Between the ages of three and six months, the urgency diminishes proportionally and the parents may exercise their judgment in attempting to control the fever. After six months of age, without other symptoms accompanying the fever, the parents will not usually endanger the well-being of the child by waiting 8-12 hours before contacting our office for advice. If temperature is less than 100.5 degrees, no treatment is necessary.

Liquid ibuprofen (Motrin can be bought without prescription) is now available to help with fever persistently over 102 degrees despite Tylenol. if your child's fever is over 102 degrees and is not due for the

next dose of Tylenol, you may start ibuprofen every 6 hours in addition to Tylenol. The dose is:

Children's Motrin (100mg/tsp)

Age	Weight (lb)	Fever Over 102.5° F
6-11 mos	13 - 17	½ tsp
12-23 mos	18 – 23	¾ tsp
2 – 3 yrs	24 – 35	1 tsp
4 – 5 yrs	36 – 47	1½ tsp
6 – 8 yrs	48 – 59	2 tsp
9 – 10 yrs	60 – 71	2 ½ tsp
11 – 12 yrs	72 – 95	3 tsp
Adult	96 – 154	4 tsp

Sponge Baths

It is advisable to dress the child in thin night clothing, to avoid heavy bedding, to keep the house temperature cool (70-72 degrees), and to give repeated tub or sponge baths for cooling only if temperature is greater than 103°. The aim of either tub or sponge baths is to bring the body heat to the surface so that it may be lost. If the bath water is too cool, shivering occurs. This may result in a rise in temperature. Conversely, if the temperature of the bath water is too warm or is the same as the body temperature, the heat loss will be minimal.

Sponge baths with tepid water are best. Reduction in temperature depends on freely moving air currents to evaporate the thin layer of water which is applied repeatedly to rotated areas of the skin. The entire body should be exposed. A sponge bath should last at least 20 minutes.

Alcohol should never be used for bathing.

The methods of temperature control, which are the most effective, are Tylenol, ibuprofen and sponge baths. A satisfactory end-point should be 101-102 degrees. Repeated sponging may be necessary as the temperature rises again. Infants between 0-2 months should be sponged and the office always notified of fever over 100.5 axillary.

Liquids

Provide plenty of liquids. Especially good are: soft drinks, popsicles, Kool-Aid, juices, and juice punches such as Hi-C and Hawaiian Punch. Children under 1 year of age should drink Infalyte.

Dosage of Acetaminophen

Drugs such as Acetaminophen (Tylenol) can be given as often as every 4 hours for fever.

The proper dosage of acetaminophen is as follows:

Age	Approx Weight Range*	Tylenol Syrup 160mg/5ml	Tylenol Regular Strength Chewables 80 mg	Tylenol Double Strength Chewables 160 mg
†Under 4 mo	Under 12 lb	¼ tsp	-	-
† 4 to 11 mo	12 – 17 lb	½ tsp	-	-
† 12 to 23 mo	18 – 23 lb	¾ tsp	-	-
2 to 3 yr	24 – 35 lb	1 tsp	2 tablets	-
4 to 5 yr	36 – 47 lb	1½ tsp	3 tablets	-
6 to 8 yr	48 – 59 lb	2 tsp	4 tablets	2 tablets
9 to 10 yr	60 – 71 lb	2½ tsp	5 tablets	2½ tablets
11 yr	72 – 95 lb	3 tsp	6 tablets	3 tablets
12 yr +	96 lb & over	4 tsp	8 tablets	4 tablets

2. CONSTIPATION

The definition of constipation will be considered here in its broadest, most commonly used terms. Constipation is the difficult, infrequent passage of stools, which are hard and dry.

Some infants seem to have considerable “pain” or difficulty in having bowel movements. They will strain, bear down, become flushed and occasionally cry when trying to have a stool. This activity is actually considered to be normal. It may be due to dietary imbalance, for example, lack of water and lack of fiber. Weak, undeveloped abdominal muscles also cause it, and by the infant being in a position other than sitting (as with the feet firmly planted on the floor when they get older). Babies can be helped considerably when they exhibit this type of straining action by gently flexing the legs onto the abdomen.

Although the usual number of stools varies from 2-4 per 24 hours, bottle-fed infants may not have a bowel movement for 24-48 hours and still be considered normal as long as the character of the stool is the same as usual. Similarly, thriving breast fed babies may go 3-7 days between bowel movements. As long as stools are of normal consistency there is no cause for alarm.

Treatment

The usual treatment for the child with hard, dry infrequent bowel movements varies, but generally, one tries to control the problem with simple measures before resorting to laxatives and enemas. When a child is constipated, several changes in the diet will help. They are: reducing the milk intake and increasing the quantity of other fluids, such as juices (prune and apple), increasing bulk-producing foods such as cereals, (bran and whole grains), fruits (apricots, prunes and raisins) and vegetables (carrots, spinach, squash and beets, etc.). If a child is straining and trying to pass a very large or hard bowel movement, they may respond to the stimulation of inserting ⅓ to ½ of an infant glycerin suppository. When these home remedies fail to correct the problem of constipation, you should always consult your doctor. Two-three ounces of apple or prime juice, diluted with an equal amount of water, will usually help constipated infants.

3. STOMACH AND ABDOMINAL PAIN

The first period when you may begin to be aware that your baby has some abdominal pain is in the first 4 weeks of life. Most babies go through this phase, characterized by more agitation, fussiness and possible colic. The best care for your baby at this time is to relax, handle the baby gently and confidently realizing that this is probably quite normal and that it will not hurt him to cry. Do not tend to overfeed the baby at this time because of his crying: it will only cause spitting up and possibly some gas.

In treating the older child, at the onset of pain, symptomatic care is safe and includes small amounts of clear liquids and a heating pad. If the pain persists for several hours please call us. If your child is to be checked because of abdominal pain, it may be suggested that a urine specimen be obtained on arrival in the office. Although there are innumerable causes of abdominal pain in children, urinary tract infections are frequently the cause (especially in girls). Additional symptoms are fever, frequency and burning with urination, urgency and recurrence of bed-wetting. Other causes of abdominal pain are gas, constipation, vomiting and/or diarrhea (see the next section) and rarely more serious causes such as appendicitis.

4. ACUTE GASTROENTERITIS

Acute gastroenteritis is the medical tem for “vomiting and diarrhea.” By definition, the passage of frequent loose watery stools is known as diarrhea, but diarrhea and recurrent vomiting typify large number of varied gastrointestinal disorders. Children are more susceptible to this type of

infection and to water and salt loss.

In addition to bacteria and intestinal viruses, it is possible that some respiratory viruses may be responsible for the loose stools associated with "colds." A number of other causes must be considered. The most important ones are diarrhea due to prolonged use of antibiotics, allergy or food intolerance, and prolonged intake of clear liquids.

Treatment

The primary aim of treatment is to relieve vomiting when present, to supply fluids to prevent dehydration, and to put the bowel at rest so that healing can occur. Clear liquids during the first day of the illness will accomplish all of these goals. When a child is persistently vomiting, it is important to "let things settle down". We generally recommend 2-3 hours of nothing to drink, and then slowly start fluids at a rate of 1 ounce every 30 minutes. After 2 hours you gradually increase the amount of fluid given each hour. Spoon-feeding small children is an effective way to slowly give fluids. After 6-12 hours, some solids may he resumed, usually in order similar to the first introduction of solids. Please see the section on diarrhea for details.

The most serious complication of acute gastroenteritis is dehydration. To recognize impending dehydration, it is essential to be familiar with some of the most common signs, so that medical advice can be obtained before fluid loss becomes severe. The most obvious sign of dehydration is failure to urinate. However, other things to note are depression of the infant's soft spot, sunken eyes, absence of tears, dry mouth, and loss of skin elasticity.

Vomiting

A few words are in order concerning some of the minor causes of vomiting, since it is one of the most common symptoms during infancy and childhood. Vomiting may occur with almost any type of infection or emotional stress. In infancy, vomiting is often nothing more than simple regurgitation due to over-feeding, failure to burp adequately, or relaxation of the muscle separating the esophagus and the stomach. This latter type of spitting or regurgitation is usually a laundry problem rather than a medical problem. Community epidemics of vomiting are common and are probably viral. We ask that you call the office to discuss your child's symptoms and treatment if vomiting or diarrhea is persistent. Please see the next section for details.

Diarrhea Routine

This is best handled by stopping all oral intakes except for small amounts of clear fluids. After 4-6 hours of clear fluids, some solids may be resumed. Milk products (formula, milk, cheese, and yogurt) may be given when some improvement has occurred, generally 48-72 hours. Infants on formula should usually spend 6-12 hours on clear liquids, and then at least 24 hours on full-strength soy formula, such as Prosobee. When stools are back to normal, you may switch to your regular formula.

Usually, the first sign of improvement is a decreasing frequency of the loose stools. If it is persistent, or if there is blood or mucus, notify our office. Do NOT make special formulations for 'clear fluids." Only use those formulations that are ready made, such as Pedialyte®. Less effective, but useful, are Gatorade or other sports drinks.

5. COMMON COLD AND COUGH

One of the most difficult problems confronting doctors and parents is the management of the common cold (also known as the upper respiratory infection, or URI). Because many viruses produce symptoms similar to those that are usually associated with the common cold, there can be an infinite number of combinations of symptoms, diseases of varying severity, and epidemics of like illnesses. Since there are so many viruses, it is impossible to isolate a vaccine for the "common cold." Likewise, since viruses are not affected by antibiotics, these drugs have no place in the treatment of upper respiratory infections; however, they may he indicated in the therapy of complications such as ear and eye infections or bronchitis.

The treatment of the common cold is primarily symptomatic, aimed at relieving the sneezing, nasal discharge and congestion, eye discomfort, sore throat, headache, cough, and fever. Tylenol may be given for the aches and pains of the common cold.

If an infant of less than three months of age develops an upper respiratory infection, it is advisable to call the office for treatment suggestions.

Treatment and Cold Medications

The same principles of treatment can be applied to children of all ages; but the most important thing to remember is that an infant cannot breathe through its mouth. Keeping the nasal passage clear may be helpful. Gratifying results occur when the thick nasal secretions are removed by suction following salt-water nose drops. These can be made with ¼ tsp. salt

in 1 cup of water. You may also buy salt-water nose drops at your store; Little Noses and Ocean Spray being common brands.

Cough

The cough serves a number of necessary functions, but it may also be detrimental if it is associated with a loss of sleep or is an annoyance to the patient. Whenever possible the cause of the cough should he diagnosed and treated. Symptomatic care is valuable in situations in which the fundamental cause cannot be removed or treated; however, most new coughs and some old ones just fade away with or without treatment. Please call the office for a persistent or severe cough, shortness of breath or high fever.

Vapor Therapy

Of the many types of treatment used to relieve cough, one of the most effective is vapor therapy. This is especially true when it is used in conjunction with a tent. Vapor provides a water-saturated atmosphere intended to moisten the mucus so that it is thin and easily removed. Cool mist vapor is preferred because of its comfort, safety and effectiveness. Either type of vaporizer must be kept scrupulously clean. Incidentally, it is absolutely unnecessary to add any type of medication to the vaporizer. Finally, when concentrated vapor is needed quickly to treat the hoarseness and harking cough associated with croup, steam from the shower is ideal. This is obtained by pulling the shower curtains closed, taking the child's clothes off, sitting him/her on the toilet and turning on the hot water in the shower. The hot water should run for about 10 minutes. The child should stay in the bathroom for an additional 10 minutes to cool off. He may then he dressed and taken into a room where a cool mist vaporizer is running.

6. ALLERGY

Allergies are a common occurrence. Symptoms include chronic nasal drainage, usually clear, and many times watery, itchy eyes. Allergy formulations include Dimetapp, Triaminic orange and Actifed - all of which can he dosed as above. Generally, children do not go to the allergist for testing until age 3 (three) - 4 (four) years. Claritin (Loratidine) may be bought without a prescription. The dose is 1 teaspoon for 25-35 pounds, 1½ teaspoons for 36-48 pounds, then 2 teaspoons. <u>All are Once Daily</u>.

7. ATOPIC DERMATITIS
(Eczema)

<u>ATOPIC DERMATITIS</u> or **<u>ECZEMA</u>** as it is commonly known, typically starts in infancy and may recur throughout life. The skin is usually described as easily irritated and very itchy. It appears dry, rough, and scaly, but may be

weeping or crusted in later stages. The skin may be also raw and bleeding from repeated scratching. Eczema tends to run in families. Many times, children with eczema have parents with dry, easily irritated skin. The good news is that eczema is generally easily controlled and leaves no scarring or permanent damage to the skin. Treatment of Eczema has several components:

1. **Avoidance of irritants.** It is important that children with ECZEMA avoid physical irritants such as wool, regular soap, and rough, scratchy clothing. All of these will irritate the skin and worsen itching and other symptoms. Other irritants include sweat, heat, infection, and stress.

2. **Avoid dry skin.** Children with eczema should bathe once daily, twice daily if doing poorly. Alpha-Ken bath oil, or Nivea bath oil (one teaspoon per quart) should be added to the bath water. You may also use Aveeno bath powder. After the child is removed from the water, the skin should be patted damp dry and moisturizer immediately applied.

3. **Cleansing.** Most soap is extremely irritating and drying to the skin. For this reason soap should only be used when necessary and on the areas that need it. Depending on the severity of your child's eczema, the choice of soap becomes increasingly important. Mild cases can usually be treated with the use of a common soap, such as Dove. More severe cases need milder soaps such as Neutrogena or Cetaphil. These may be obtained at your local pharmacy or store. Remember to use as little soap as necessary.

4. **Steroid Creams.** Steroids are medications that decrease inflammation. Under the direction of your doctor, you will use weak steroid creams on the worst areas only. We usually recommend 0.5% or 1% hydrocortisone cream (non-prescription) to start. If this is not effective, we will prescribe a stronger cream. Prescriptive steroid creams include Cutivate, Elocon, and Aclovate, among many others. A non-steroidal cream, such as Elidel or Protopic, may be prescribed. Generally, these creams are used once or twice daily for one week during acute flare-ups. In general, if proper care is taken, steroids are needed infrequently.

5. **Moisturizers.** Dry skin worsens eczema. For this reason, it is important to avoid dry skin. Dermatologists generally use moisturizers such as Vaseline Dermatology Formula, Cerave, Lubriderm, Eucerin, Moisturel, Nivea, and Aquaphor. We found the creams work best. These should be applied twice daily, and immediately after bathing, to all skin areas. These can all be obtained at your local pharmacy without a prescription.

6. **Itching.** Eczema is extremely itchy. Scratching makes your child uncomfortable and worsens the eczema. Along with the methods used above, medications such as Atarax or Benadryl may be taken orally to

decrease itching. Benadryl may be obtained over the counter, but Atarax is by prescription only. If your child is having extreme itching, please discuss this with your child's physician.

With proper care, your child should have no long-term scarring. The treatment outlined above is the first stage of treatment for eczema. There are many other soaps, moisturizers, and steroid creams available if first stage measures don't clear up the skin. Occasionally we may wish to consult a dermatologist for more expert help. If you have any questions, please feel free to ask.

8. ASTHMA

Asthma is defined as intermittent or daily cough and wheeze caused by tightening of the airways (bronchoconstriction) and mucous production. Children with asthma may have daily wheezing or only cough at night or after exercise. Asthma does not permanently injure the lungs and with appropriate treatment most children lead a normal active life.

In fact 50**%** of children with asthma may have no symptoms as adults. Asthma tends to run in families with allergic symptoms and is triggered by environmental factors such as dust, weather, pollens, cold and especially upper respiratory infections. Fortunately, there arc numerous treatments available and working together we should be able to help your child stay active and healthy. We refer children with severe asthma, not responsive to the commonly used medications, to a pediatric pulmonologist (children's lung specialist) for consultation.

9. SORE THROAT

The child with a sore throat should be treated with symptomatic care. This includes Tylenol, gargling for the older child, and the use of simple lozenges (Cepacol, Chloraseptic, etc.). We never use antibiotics to treat a child who has a sore throat unless he is examined and/or a throat culture obtained. The importance of the proper diagnosis of a streptococcal infection of the throat cannot be overemphasized. The simple irritated throat that accompanies a viral infection and is associated with the "runny" nose and cough is of minimal importance. There is no effective therapy for a viral infection. The use of an antibiotic for a sore throat other than a strep throat is unnecessary. When a child has complained of a sore throat persistently or has a fever and is ill, that child should be examined and have a test for streptococcal infection.

10. EARACHE

External otitis or swimmer's ear usually occurs during the summer months and the outer ear is very tender to the touch. Many times antibiotic ear drops

will effectively treat an external otitis please call during office hours if you feel your child needs treatment. Your child should stay out of the pool for 3-5 days during the treatment, If your child is not better after 2-3 days, is worse, or develops a fever over 100.5: please schedule an appointment. After your child is well, preventing future occurrences is critical. Using Swim Ear (over the counter at the pharmacy) or a 50-50 mixture of alcohol and vinegar in both ears after swimming will decrease the chance of a recurrence. Motrin is helpful for the pain of swimmer's ear.

Middle ear infection (otitis media) is most often secondary to an upper respiratory infection. The tympanic membrane (eardrum) becomes inflamed, distorted, and stretched. There is fluid or pus behind the tympanic membrane causing the pain. The initial treatment of either type of earache is Tylenol in appropriate doses. Eardrops are useless in the treatment of middle ear infection (unless the child has tubes). Auralgan drops may alleviate the pain. In the middle of the night when pharmacies are not readily available, a few drops of slightly warmed olive oil are sometimes helpful. The earache is definitely relieved by eradicating the infection with an appropriate antibiotic. However, in many cases the earache may disappear even though the infection persists. This is the case when pressure on the tympanic membrane is equalized, or relieved by rupture and drainage of fluid or pus. Despite the absence of pain, an ear infection will need proper treatment. It is our policy to examine all children with earaches in order to determine the exact cause and institute the proper treatment. 10 to 24 days after instituting therapy, the child's ear is rechecked to determine the response to treatment.

Most ear infections are cleared with the use of antibiotics, but several courses are sometimes necessary. Children with very persistent (lasting over 10 weeks), or numerous recurrences (greater than 6 or 7 per year) may require a referral to an Ear, Nose and Throat (E.N.T.) specialist. The E.N.T. would consider the placement of tubes in the eardrums under anesthesia to decrease the number of infections and drain chronic fluid build up. Tube placement is a safe and generally useful procedure, but like all surgeries, should not be undertaken unless it is definitely necessary.

11. CHICKEN POX

Chicken pox is a viral infection famous for its rash. The rash is initially red bumps, which form a blister and then break and scab over. Normally the rash may continue to break out for 4 (four) to 5 (five) days. Chicken pox is very contagious (the virus is airborne) and infected persons are contagious for 2 (two) days before the onset until 1 (one) week after the rash starts and all the

blisters are scabbed over. The incubation period is 7 to 21 days, but averages 12 to 14 days. Treatment includes Tylenol for fever **(never aspirin** or **Ibuprofen),** Benadryl (see bites/strings for dosages), and Aveeno baths for itching. Your child should be seen if the following develop:
1) Fever greater than 4 or 5 days, 2) if you feel some of the lesions are becoming infected (they have a large red area around them), 3) your child develops persistent vomiting, or is confused, disoriented or very lethargic. 4) the eyes become red or you see a chicken pox lesion on the eyeball (on the eyelid is okay).

There is an antiviral medication, Zovirax, which modifies chicken pox. Zovirax does not "cure" or "kill" the chicken pox virus, but prevents its dividing and multiplying. Generally, if started within 36 hours of the first blisters, it will decrease the number of blisters which form and slightly shorten the illness. Zovirax is definitely indicated if your child is over 12 years of age, has any chronic disease (such as diabetes), has been on inhaled or oral steroids in the past month, or has any deficiency in his immune system (unable to fight infection normally). Zovirax is sometimes helpful in other special situations. Please call during office hours (weekends or weekdays), if you think your child might be a candidate for Zovirax.

The vaccine for chicken pox is available and is required by the American Academy of Pediatrics and The Center for Disease Control for all children over age 12 months who haven't already had chicken pox. We administer the first dose at the 1-year-old check up. See the section on vaccines for details. A second dose is given after the 4th birthday.

12. INJURIES

The active child is frequently involved in accidents that result in serious injury. There are certain basic rules that must be followed in evaluating the extent and the treatment of the injury.

Cuts and Abrasions

When a child is bleeding from a laceration (cut), it is essential to stop the bleeding as quickly as possible. Applying pressure to the wound with a clean cold cloth does this. Once the bleeding has stopped, one must determine whether or not the wound needs to be sutured. There is NO way that this evaluation can be done by telephone; therefore, it is recommended that the child be evaluated after any accident that results in anything other than a simple, superficial cut or abrasion.

If the parent decides that the child has a superficial cut or abrasion that can be treated at home, the wound should be cleansed with soap and water, a

topical antibacterial ointment (i.e. Bacitracin, Polysporin, or Mycitracin) applied, and the area covered with a Band-Aid. Generally, there is no need for giving a Tetanus booster (especially in most household accidents); if a child is up to date on immunizations or has had a booster shot within a five-year period. Any question concerning the need for a Tetanus booster can be answered by calling us **during office hours.** There is NO urgency for giving the Tetanus booster since there can be a waiting period of four to five days before the injection is given.

Burns

The youngster with a burn should be cared for in the same manner as the one with a laceration. A simple small burn may be treated at home. The doctor should see anything more extensive than this. If the simple burn is painful, application of ice to the burned area may relieve the pain. Do NOT smear a burn with butter or any similar greasy substance; this will neither relieve the pain nor improve the burn. Keep the burned area clean.

Head Injuries

Head injuries are very common in the pediatric age group, but such injuries are rarely serious. The child who strikes his head should be watched carefully for certain abnormal signs. Although vomiting and drowsiness are relatively common after non-serious head injuries, persistent vomiting and excessive drowsiness are signs of a serious head injury. Any child who cries for a long period of time after injuring his head will usually fall asleep from the fatigue. If the child can be awakened at reasonable intervals (every hour) he is reacting normally. When he cannot he easily aroused, consult us. Likewise, the child who has had even a short period of unconsciousness must be examined. Other symptoms, which should be carefully evaluated, are dizziness, blurred vision, tingling or weakness of an extremity, and vomiting. Finally, the injured child's pupils should be observed. They should he round, equal in size, and the same shape. Contact us if the injured child's pupils differ from any of these descriptions.

Eye Injuries

When a flying object strikes the eye, the child's first reaction is to keep the eye closed at the onset. Later he will open the injured eye. If the eye is extensively swollen and cannot be opened easily, the child should be examined either in our office or at the emergency room. If the cornea is scratched there will be excessive tearing and photophobia (pain in the eye caused by light), and the eye will be kept closed at all times.

We should always see corneal scratches or abrasions. Foreign bodies in the eye that cannot be removed easily, or ones that produce excessive tearing, pain, and photophobia, should also be examined. Chemical or other irritating liquids that get into the eye should be removed by washing the eye with **large** quantities of tap water. Call AFTER washing is instituted.

Stings and Bites

Three types of "bites" occur in the childhood age group. These are insect, animal and human bites. The insect "bite" or sting is characterized by redness, swelling, and/or itching. It can be treated with ice. If the child develops hives or a generalized reaction to an insect bite, please contact us; this requires specific, urgent therapy. Benadryl is also helpful for itching. The dose is ¼ teaspoon for every 11 (eleven) pounds of body weight. Should the bites become increasingly red or swollen, especially after the first day, we would like to examine the child for secondary infection.

Animal bites are very common and the parent's concern about proper treatment is appropriate. A simple animal bite should be treated with local cleansing (soap and water) and the application of an antibiotic ointment (Bacitracin, Polysporin, Mycitracin). If the bite is severe, the child should be taken to the hospital emergency room. The question of rabies is almost always brought up. Both domestic (cat or dog) and wild (fox, skunk, bat) animals can carry rabies. Anytime the animal has not been properly immunized a risk of rabies exists. This will be discussed when the bite is examined by the emergency room physician or us. If you don't feel the bite is serious, please call about rabies during office hours. A rodent (rat) bite is usually not of any significance for rabies. The rules for giving Tetanus shots for an animal bite are the same as for any other injury and you should call the office if you have a question.

Human bites are prone to infection. It is important to clean them thoroughly and to use a topical antibiotic ointment.

Sprains and Fractures

Following an accident, the question of whether a youngster has sustained a sprain or a broken bone will often arise. A sprain is an injury to the ligaments around a joint resulting in pain, swelling, and tenderness. If these symptoms are mild and the youngster has minimally impaired function, very little need be done. When the pain and swelling are extreme, distinguishing a sprain from a fracture can only be made by x-ray. If diagnosis of a sprain is made, the afflicted part is kept at rest, and cold is used. Ice in "Baggies," wrapped in a thin towel, may be applied for 10-20 minutes every four hours during the first twenty-four hours. Thereafter heat is used. Tylenol or Motrin, etc. may be helpful in relieving the pain.

Not every injury requires an x-ray to diagnose. We are careful to avoid unnecessary x-rays.

13. POISONS

The young child is very inquisitive and, unfortunately, will put almost anything in his or her mouth. If your child should swallow anything that is potentially dangerous, **call the Poison Control Center at 1-800-222-1222**. Someone there will advise you as to the proper course of emergency management. Certain chemicals such as strong acids (hydrochloric, sulfuric), strong bases (lye. Drano) and volatile hydrocarbons (gasoline, kerosene) should never be removed from the stomach by making the child vomit. If your child ingests one of these substances and you are unable to get immediate medical advice, take your child and the container of ingested material to the nearest emergency room. If you are in doubt as to what you should do when either the substance or the time of ingestion is unknown, please take the child to the emergency room.

14. RASHES

Some of the causes of rashes in childhood are allergy, skin infections, certain systemic diseases (measles, chickenpox, etc.) and a large number of unknown causes. It is impossible to diagnose accurately any of these rashes by telephone. Since the only rash associated with a medical emergency is one that appears as tiny pinpoint hemorrhages (petechiae) or bruises beneath the skin in an ill child with fever: should these pinpoint hemorrhages and fever occur, contact us immediately.

Early symptomatic treatment of rashes includes baking soda baths (/2 cup to 1 cup per tub of water) for itching, and a mild lotion such as Calamine. If the rash is accompanied by fever, it is advisable to contact the office so that the child can be examined. Many viruses cause rashes. Some types of rashes are associated with strep throat or other significant illnesses, so checking out a persistent rash, or a rash associated with fever, is a good idea.

GENERAL TOPICS OF CHILD CARE

What Sort of Shoes for My Child

Child foot specialists are now in general agreement that in most cases, no special types of shoes are needed for a child's feet. The main purpose of shoes is to protect the feet from injury and to keep them warm. In general,

shoes will not keep feet from turning in, from turning out, from going flat or prevent any other such problems, unless a particular type has been prescribed by your doctor. Doctors are coming to realize that a child's feet will grow on their own and it is very difficult to influence this with shoes. Your child can go to low shoes or sneakers at any time when she is able to keep them on. The most important thing about shoes is that they fit well. A growing child will often outgrow shoes in a period of 8 to 10 weeks, and a parent must be ready to purchase new ones when this happens.

It becomes quite obvious then that there is no reason to buy more expensive shoes that will last longer than this period of time. In checking the fit of a shoe, with your child standing, there should be about one thumb width between the great toe and the tip of the shoe. It is wide enough if you can pinch the upper part of the shoe between the thumb and index finger with the child standing. It is very important that you feel over the little toe, the area where shoes are often very tight. Going barefoot is fine for growing feet, but be very careful that your child is not around an area where her feet can be injured.

Urinary Tract Infection

Urinary tract infection (U.T.I.) is defined as a bacterial infection of the bladder and/or kidneys. It is very difficult to decide if the infection is confined to the bladder or has also spread to the kidney, which is a more serious infection. In general, children with high fever, vomiting, or that appear ill, are felt to most likely have kidney infections. The causes of U.T.I. are variable. In young infants it is common to find congenital (inborn) abnormalities of the kidney, bladder, or connecting tubes (ureters). In young children bacteria may travel through the blood and "land" in the kidney cause infection. A very common cause of infection in young children is urinary reflux, in which urine backs up from the bladder and flows toward the kidney during normal voiding. Normally, the bladder wall tightens and does not allow the urine to go back toward the kidney during voiding. This is a very important cause of U.T.I. and may cause long term, permanent damage to the kidneys. In older children and adults, particularly in females, a common cause of U.T.I. is the short distance between the vagina and the bladder, allowing bacteria to "climb up the urethra" into the bladder.

Diagnosis

In very young children there are no reliable signs of U.T.I. Commonly, infants will be fussy, irritable, and may have fever, vomiting, or diarrhea. Obviously, all of these are not specific to U.T.I. In older children symptoms

such as burning on urination, frequent urination, and pain on urination are suggestive but not diagnostic. It is very important to always obtain a clean urine specimen in order to make the diagnosis. A child under two is very difficult to obtain a clean specimen on. Placing a sterile bag over the genitalia was very common in the past to collect urine. This is particularly useless in females, as all urine must pass the vagina to reach the bag. Most experts feel that bag specimens are merely useful for screening and that an infected bag specimen should always be repeated before the diagnosis of U.T.I. is made. More appropriate specimens can he obtained by catheterizing young children using sterile catheters. In older children who are toilet-trained, a "clean" urine specimen may sometimes be obtained if the child is carefully cleansed and will void into a cup. However, many times these specimens are not as clean as we would like to think. The rule is, when in doubt about the cleanliness of a sample; always repeat it before making a diagnosis of U.T.I. The urine is sent to the lab and examined for the presence of bacteria and if present, the diagnosis of a U.T.I. is presumptively made and antibiotics are started. The urine is always placed in an incubator for 24-48 hours to see if bacteria will "grow". If a U.T.I. is present, bacteria should always grow unless the child is already on antibiotics. Occasionally, urine may appear clear under the microscope but "grow" bacteria. This is still a U.T.I.

Treatment

Antibiotics are the cornerstones of treatment of acute U.T.I. Common antibiotics used are Amoxicillin, Bactrim, Suprax and Omnicef. Antibiotics are usually given for approximately 10 days. Mildly ill children may take oral antibiotics at home, but young infants and very ill children may be hospitalized initially. It is very important that appropriate follow-up be obtained in all children with a proven urinary tract infection. A child who is still running fever and having symptoms after three days should have a repeat urine culture obtained at that time. There is approximately a 25 percent chance of relapsing into another U.T.I. after antibiotics are discontinued.

Long Term Complications

Certain congenital abnormalities, especially urinary reflux, as discussed above, may lead to long term, permanent kidney damage. For this reason it has become standard practice to evaluate the bladder and kidneys of children suffering from U.T.I. Boys and girls should have a kidney sonogram after their first U.I.I.

X-Ray Evaluation

Evaluation of the urinary tract requires X-ray analysis of the kidneys and bladder. Evaluation of the kidney is usually done by renal (kidney) sonogram. In this technique ultrasonic waves are used to image the kidney and help the radiologist evaluate its structure

Long term Treatment

Treatment following U.T.I. is variable depending on the specific diagnosis. A child with U.T.I. and normal X-rays may merely need frequent urine cultures. In any case, it is very important to have frequent urine cultures in children with previous U.T.I.'s or known urinary tract abnormalities. If your child has U.T.I., it is important to avoid constipation. Let us know if your child does not have at least 1 soft stool daily.

Bedwetting

Bedwetting or enuresis is a common problem. Thirty percent of four year olds and 10 percent of 6 year olds are affected. The boy-to-girl ratio is 3-2.

The cause is not specifically identified in many children. Some experts feel nerve control of the bladder is 'immature" and until the nervous system matures enuresis will continue. Some experts feel that nighttime production of DDAVP (the hormone that reduces urine production while we sleep) is low and low DDAVP causes increased urine production leading to enuresis. Occasionally a child will be found to have a bladder or kidney infection (urinary tract infection). Some experts feel children with enuresis are "deep sleepers", but research has not substantiated this. Often no special cause is found.

Medical Information Needed: A urine screening: both a urinalysis and a urine culture. Family History: it's common for bedwetting to "run" in families. Rarely x-rays of the kidney and bladder are necessary if a urinary tract infection is found, or if both day and night wetting is present.

Things Not Helpful: Severely restricting fluids before bedtime (shouldn't drink a gallon, but a glass of milk or water is okay). Waking them up after they have gone to bed to empty the bladder (permanent results require the child to do this himself). Punishment is ineffective and compounds your misery.

Treatments

Approaches such as a buzzer to wake a child up if he wets the sheets are usually not effective until the child is six years old. The buzzer is designed to train the child to wake up in response to his bladder being full. The ultimate goal is for him or her to control their bladder and stay dry through

the night without waking up. This approach is about 75% effective. We always try the buzzer first because if it works, it's a cure.

Medications

Medications for enuresis are about 75% effective. However, they do not "cure" the problem and can be taken daily until enuresis is outgrown.

1) Imipramine is an anti-depressant and how it decreases enuresis is unknown. It is very inexpensive and is usually taken 1 hour before bedtime. Its main side effects include dry mouth, difficulty starting urination and irregular heart rate. Heart problems are usually not a problem at the dose we use, but an EKG might be required before starting to insure there are no underlying cardiac problems we don't suspect. An overdose of imipramine is very dangerous and control of the medication is very important.
2) DDAVP is a nasal spray or tablet, which gives the body's natural levels of DDAVP a nighttime boost. Less urine is formed and enuresis generally decreases. It is very expensive. Its side effects are rare, but occasionally water overload has been reported and seizures have occurred. For that reason, we recommend no fluids after 7 p.m. DDAVP is used once nightly before bedtime. The starting dose is one squirt in each nostril (or one tablet by mouth) and if not effective in 3-4 days, the dose is increased to the maximum, which is two squirts in each nostril (or 3 tablets by mouth). If not effective, DDAVP is discontinued. If effective, the dose is continued for 4-6 months, and then slowly decreased as long as enuresis does not recur.

Is bedwetting a psychological issue? Usually not, although, it can become so. If you approach it from a punitive, "why can't you be dry like all the other guys your age" approach. Also, realize that kids who have been dry for several years may start wetting the bed in response to psychological events, such as divorce, death, or a major move. When a child who has been dry starts wetting the bed, careful consideration should be given to what's going on in the family and at school.

Acne Treatment

1) Plugging of oil glands causes acne. Plugged glands are visible as white- heads and blackheads. If the glands burst, bacteria in the skin and chemicals from the glands cause redness and soreness, commonly known as zits or pimples.

2) Foods rarely affect acne so you do not need to avoid any foods unless you discover some foods worsen your acne. If this happens, avoid the offending foods.
3) Oil in the skin may worsen acne, for example, oil you put on your hair or oil based makeups. There are water-based makeups for women with acne available at any good department store. Do not apply makeup thickly. Be sure and use water based (oil free) sun block for skin protection.
4) We are going to treat your skin with topical medicines applied to your skin. These medicines are somewhat drying and irritating. You should avoid other chemicals on your skin, for example, non-prescription acne medicines, and you should wash your face no more than 3 times a day, using a mild soap, such as Aveeno, Neutrogena or Purpose. You can use an alcohol preparation, such as Therapads to wipe excess oil off your face, if you wish.
5) You need to use the topical medicines everywhere you are having trouble right now and everywhere you sometimes have trouble. These medicines will not cure the pimples you have now, but will make them go away more quickly. They will also prevent new ones from forming.
6) You should not use your fingers to press your pimples. This often makes them worse and rarely can lead to serious infection.
7) Your acne will get better slowly over the next 3-4 months. You need to be patient and allow these medicines to work. They are not curing your acne; you will have to use these medicines daily until you outgrow this problem.

Some Specific Instructions For Topical Medicines:

a. Benzoyl Peroxide (Benzac, Persa-Gel, etc.)

   Apply a thin film everywhere you may get acne lesions. Rub in gently. Do not wash off and use once a day. If your skin becomes too irritated, stop for a few days, or use every other day until your skin gets used to the medicine.

   This medicine is available without a prescription. You want the 5% benzoyl peroxide (products such as Oxy-5). Talk to the pharmacist if you're not sure what to choose.

   Rarely, benzoyl peroxide causes an allergic reaction with marked redness, swelling and or itching of the skin. Stop the medicine and call us, if this happens to you.

As your face gets used to it, you may use this medicine 2 times a day. You can also increase the strength to 10%.

Your face will be more sensitive to sunburn and it is very important to use sun block with an SPF of at least 30.

b. Retinoic Acid (Retin A): Adaptalene, a Retin A product, is now over the counter.

   Your skin may become irritated as you begin this medicine. Wait at least 30 minutes after washing your face before applying it. Use it everywhere you get acne. If you are also using benzoyl peroxide, apply one in the morning and the other in the evening.

   You need only about a pea-sized amount of this medicine to cover each section of your face (forehead, chin, and cheek). If you use too much, the irritation will be worse.

   If your face is becoming too irritated, stop the medicine for a few days, or use it only every 3 days. If your face is tolerating it well, use every day.

   Retinoic acid may make you sunburn more easily and more severely. You should use a sunscreen with a rating of at least 30.

   Occasionally, your acne will worsen about 3-4 weeks after you begin using retinoic acid. Keep using it because this effect is only temporary.

   Remember, it takes about 3 months for this medicine to work.

c. Topical Antibiotics (Cleocin T, EryDerm, etc.)

   We may have you use these in addition to other topical medicines. Apply everywhere you get acne lesions. Use the number of times a day we recommend.

   We may give you oral antibiotics. You may take this 1 hour before, or 2 hours after meals because your stomach must be empty to permit absorption of the medicine.

   If we give you oral erythromycin, sometimes it will upset your stomach. Take it after meals and with a snack at bedtime, if you have abdominal pain, stop and call us.

   Once your face is better, we will try to stop your oral antibiotics completely or at least decrease the dose. You may need to use them again during periods when your acne flares up.

Call us if you get a rash, diarrhea or any other worrisome symptom when taking these antibiotics. Occasionally, females will get an itchy vaginal discharge due to a yeast infection, which can be treated with medication.

VACCINATIONS

DTaP Vaccine

At his two-month checkup your child should receive his first DTaP vaccine immunizing him against diphtheria (D), tetanus (T), and pertussis (P). This vaccine is given in five doses, the first three at two, four, and six months. A fourth dose is given six to twelve months after the third dose, usually around fifteen months of age. Then your child will receive another shot before he enters school, between four and six years. This "booster" shot raises your child's immunity against these diseases to higher levels.

Within the first twenty-four hours after the shot, your baby may be irritable and less energetic than usual. The area where the vaccine was injected may be red and sensitive, and he may have a low-grade fever (less than 101 degrees Fahrenheit (38.9 degrees centigrade). These normal reactions should last no more than forty-eight hours. They can be treated with acetaminophen given every four hours (See the chart under fever). Do not use aspirin.

Diphtheria, tetanus, and pertussis are dangerous diseases.

The dangers include:

1) Four out often people who get tetanus die from it.
2) Before this vaccine was available, one out of fifteen people who got diphtheria died from it.
3) One out of one hundred babies less than six months who get pertussis die from it. (The overall death rate is one in one thousand, including older infants.)
4) Nearly three out of every four children who get pertussis require hospitalization, and one out of five develops pneumonia.

The current vaccine, DPT acellular (DtaP) is as effective as the older vaccine. The difference between the two vaccines is that the older DPT is derived from the whole pertussis cell and the new vaccine is derived from specific components of the pertussis cell. DTaP generally causes less fever, irritability and swelling at the injection site, and extensive clinical trials have shown it is also safe and effective in infants.

Polio Vaccine

Polio is a viral disease that can paralyze some muscles of the body. The illness may be mild to very serious, depending on the muscles involved and the severity of the involvement. Fortunately, polio is not seen much in the

United States anymore because there are vaccines to prevent it. However, current concerns about possible use of polio in bioterrorist attacks necessitate continued vaccination.

The polio vaccine comes in two types: an oral vaccine and an injectable "killed" vaccine. The oral live vaccine (Sabin) has been around for many years and has been tremendously successful (no wild polio reported in the Americas for several years). However, there is a small chance the poliovirus in the vaccine could infect either the patient or another unvaccinated person who comes into contact with the patient. Because of this, only the injectable vaccine has been offered in the U.S. since January 1st, 2000. Currently a child receives the Salk (injectable) at their 2-month, 4-month, 9-month and 4-year check ups.

MMR Vaccine

At twelve months your child will receive a single shot immunizing him against mumps, measles, and rubella. Though these diseases are best known for the rashes (measles and rubella) and glandular swelling (mumps) they produce, each may also cause serious medical complications. Immunizations against these diseases rarely cause any serious side effects, but your child may experience the following reaction, beginning seven to ten days following the injection:

1) A mild rash.
2) Slight swelling of the lymph nodes in the neck or diaper area.
3) Low-grade fever.
4) Sleepiness.

If your child is taking any medication that interferes with the immune system, or his immune system is weakened for any reason, he should not be given the MMR. A second MMR is required at the 4-year check up.

Haemophilus B Conjugate Vaccine (also called Hib)

A vaccine against bacterial infections caused by the bacteria **Haemophilus influenza B** is required for children beginning at two months of age.

This illness used to cause 5000 cases of meningitis and 2000 deaths per year in the United States, until its introduction in the mid 1980's.

Other infections include pneumonia, infections of the bones and joints, and epiglottis. The vaccine appears to have no serious side effects, but low-grade

fever and mild tenderness at the injection site do occur sometimes. Four (4) doses are required; at the 2, 4, 6 and 15 months well visits.

Hepatitis B Vaccine

Hepatitis B, a viral infection of the liver, infects approximately 300,000 Americans per year and there are about 1,000,000 chronic cases of hepatitis B in America. Chronic hepatitis B infection is a leading cause of liver failure and liver cancer and about 5,000 people per year die from these causes. The Public Health Service, The Center for Disease Control, the American Academy of Pediatrics and the American Committee of Immunization Practices have all recommended routine vaccinations of all children for hepatitis B. The vaccination process requires 3 shots over 6-12 months. It is 95% effective and the side effects include 3-30% risk of pain at the injection site and a 6% or less chance of fever over 100. High risk individuals include those routinely exposed to blood (health care workers), staff of institutions for the mentally disabled, people who receive blood products or are on hemodialysis, household contacts of HepB carriers, adoptees from countries where HepB is common, IV drug users, homosexual or bisexual men, sexually active (i.e. with different partners) heterosexual men and women, international travelers who go to high risk countries and inmates of correctional institutions. Infants of mothers who are HepB carriers are vaccinated on a different protocol and this should be discussed with your pediatrician. The State of Texas requires all three shots for school entry.

Chicken Pox Vaccine

The dose is one injection at 12 months and a second after the 4th birthday. The chicken pox vaccine is required for school entry.

Side effects include a 15% risk of fever (over 102) from 0-42 days after vaccination; 3% chance of developing vesicles (blisters) near the injection site, 4% chance of developing generalized vesicles and 20% chance of soreness at injection site. The risk to adults and adolescents thirteen (13) years and older were 10% fever (over 100); 20-30% soreness; 3% vesicles near injection site and 5% generalized vesicles.

The vaccine should not be given to anyone allergic to neomycin, on immunosuppressive drugs such as steroids, with any type of cancer or malignancy, with untreated tuberculosis, with a congenital or acquired immune deficiency (AIDS), an illness with fever or pregnancy (women

should not become pregnant for three (3) months after vaccination). Because the vaccine is potentially contagious, it should also not be given to individuals in close contact with persons who arc immunocompromised or pregnant women who have NOT had chicken pox. Recipients of the vaccine should not use aspirin and other salicylates for six (6) weeks.

Prevnar (Pneumococcal Conjugate Vaccine)

Prevnar immunizes the body against the thirteen most common pediatric strains of Streptococcus pneumonia, a bacterium that is the leading cause in children of meningitis, bacterial invasion of the blood stream, pneumonia, ear infections and sinusitis. There are approximately 90 strains of S. pneumonia and the seven strains included in Prevnar account for 90% of the disease in children less than 6 years of age. As you may have heard on the news or read in magazines or newspapers, the incidence of resistant bacteria, especially S. pneumonia, has become a worldwide problem and Prevnar contains the strains most commonly associated with penicillin resistance at the current time.

The efficacy of the vaccine was tested in a large California study involving 37,816 patients Prevnar very significantly decreased the incidence of meningitis, bacterial infection of the bloodstream and pneumonia. There was also a modest decrease in the number of ear infections and placement of tympanostomy tubes in children due to recurrent ear infection.
Side effects from the vaccine include: local reactions such as redness, swelling or tenderness at the injection site; and systemic reactions such as fever (20% over 101 F.), fussiness (50%), drowsiness (30%) and decreased appetite (20%). **It is important to note that these statistics were derived from children who also received the other routine vaccines of childhood simultaneously (DTaP, Polio, Haemophilus influenza) and it is well known that these other vaccines may cause the systemic side effects listed.**

Prevnar is routinely started in infants at age 2 months. Infants receive 3 doses about two months apart and a booster after age 1 year. Children 7-11months receive 2 doses at least 4 weeks apart and a booster after age 1 year. Children 12- 23 months old receive 2 doses at least 2 months apart. Children 24 months and older receive 1 dose. There are no current recommendations for further boosters except that the currently available 23 strain vaccine may be used as a booster for children 2 years and older. The State of Texas mandates Prevnar vaccinations for all pre-kindergarten children.

HEPATITIS A VACCINE

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). Each year, an estimated 180,000 Americans contract hepatitis A**,** with most cases resulting from person to person transmission during community outbreaks. Furthermore, cases of hepatitis A are highest among children 5 to 14 years of age with about one third of those cases involving children less than age 5. HAV is found in the stool of persons with hepatitis A. It is usually spread by close personal contact or sometimes by eating food or drinking water containing HAV. A child or adult that acquires hepatitis A infection may exhibit the following symptoms such as (1) fever, (2) fatigue, (3) loss of appetite, (4) nausea, (5) abdominal discomfort, **(**6) dark urine, and (7) jaundice (yellow coloring of the skin and white part of the eyes). On average, infected adults may lose more than 5 weeks of work. As many as 22% of patients are hospitalized and in rare cases have caused death. Up to 15% of patients experience a relapse and symptoms may last up to 6 months. Children and adults with hepatitis A can easily pass this disease to other household members.

Children 1 year of age or older receive the Hepatitis A vaccine. Two doses of the vaccine given at least 6 months apart are needed for lasting protection. Hepatitis A vaccine may also be given at the same time as other vaccines. The most common adverse reaction reported following vaccination were, headache and injection site soreness. As with any vaccine, however, it is possible that a rare adverse reaction may occur. It should not be given to anyone with known hypersensitivity to any component of the vaccine.

Receiving the hepatitis A vaccine is much safer than getting the disease. The Center for Disease Control and Prevention (CDC) has recommended that all children in state of Texas should be considered for vaccination against hepatitis A virus. The State of Texas mandates Hepatitis A vaccinations for all pre-kindergarten children.

Flu Vaccine

You may have seen or read much about the flu vaccine in the media. Here are the facts. The vaccine is usually administered in the fall, from October until mid November, but may be administered later if you haven't contracted the flu.

Children who are candidates for the vaccine include those who want to avoid the flu, at their parents' discretion. However the following groups of children should definitely receive the vaccine yearly.

All children 6 months-18 years old.
Asthma, cystic fibrosis or any other chronic lung disease.
Cardiac disease.
Diabetes mellitus.
Immune disorder or HIV infection.
Sickle cell disease or other hemoglobin problems.
Illness requiring long-term aspirin therapy such as rheumatoid arthritis or Kawasaki's disease.

Furthermore, starting in 2008 the vaccine is recommended for all children 6 months to 18 years old. Other persons who should be vaccinated include those who come in contact with someone in a high-risk group, including their family members and health- care workers.

The vaccine may be administered to children over the age of 6 months. The vaccine must be administered yearly because of the annual variation in the flu strain. Protection from the flu is as high as 95% and some studies show decreased incidence of ear infections as well.

Reactions to the vaccine are few and may include fever in the first 24 hours after vaccination for young children. Those older than 12 may experience pain and redness at the injection site. Children who are allergic to eggs should not receive the vaccine.

If your child does contract the flu, the best treatment is rest, drinking plenty of fluids and acetaminophen or ibuprofen in age-appropriate doses. There is medicine available that may lessen the symptoms caused by some strains of the flu, but there is no cure.

If you would like your child to receive the vaccine, or have any questions, please contact the office.

Rotateq or Rotarix

Rotateq and Rotarix are vaccines given by mouth for protection against Rotavirus. Rotavirus is the leading cause of severe gastroenteritis (vomiting and diarrhea) in infants and young children. Over 55,000 hospital admissions occur each year due to dehydration by rotavirus, and there are more than 200,000 ER visits. The most severe cases occur between 6 months and 24 months. The first dose of rotavirus vaccine should he given between 6 - 12 weeks of age. One or two (depending on which rotavirus vaccine was used for the initial dose) additional doses are given at 4 - 10 week intervals. It will typically be offered at the 2, 4, and possibly 6-month well visits.

Gardasil

Gardasil is a vaccine to protect young women from HPV (human papillomavirus). HPV is a common virus that can cause cancer and genital warts. HPV is spread through sexual contact. HPV is the major cause of cervical cancer, and is also associated with several other types of cancer in both men and women. HPV is the most common sexually transmitted infection in the United States. HPV is most common in young women and men who are in their late teens and early 20's. The Advisory Committee on Immunization Practice recommends routine vaccination for girls **and** boys 11-12 years of age. The vaccine is given in a series of three injections over a six-month period.

Tdap: Adacel or Boostrix

A vaccine for adolescents and adults that protect against Tetanus (lockjaw), Diphtheria, and Pertussis (whooping cough). Tetanus, diphtheria, and pertussis are all caused by bacteria. Diphtheria and pertussis are spread person to person. Tetanus enters the body through cuts, scratches and wounds. Adolescents 11 through 18 years of age should get at least one booster of Tdap. Adolescents who have already received a booster of Td (previous tetanus booster) are encouraged to get a dose of Tdap as well, for the protection of pertussis. Adults who expect to have close contact with an infant younger than 12 months of age should also get a dose of Tdap from their healthcare provider. Beginning August 1st 2009, all children in 7th grade and older will be required to show proof of Tdap vaccination.

Menactra

Menactra is an injectable vaccine for meningococcal disease. Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2-18 years of age in the United States. Meningitis is an infection of the fluid surrounding the brain and spinal cord. Meningococcal disease can also cause blood infections. Menactra is recommended for all children at their routine 11-12 year check-up, with a booster 5 years later. For those who have not received Menactra previously, a dose is recommended at high school entry. Menactra is also recommended for other people at increased risk for meningococcal disease such as college freshman living in dormitories due to the close contact with peers. Beginning August 1st 2009, all children in 7th grade and older will be required to show proof of meningococcal vaccination.

Russell R. McDonald, M.D.
Scott L. Katz, M.D.

WELL BABY CHECK-UPS
AND
IMMUNIZATION SCHEDULE

Your baby will require certain immunizations for protection against common childhood diseases. The following schedule is a general guideline, but we will recommend specific ages for immunizations.

Age	**Visit**	**Vaccinations/ Laboratory**
3 – 5 days	Feeding, jaundice check.	**None**
2 weeks	Well Baby Check 2nd newborn screen	HBV (If not done at birth)
2 months	Well Baby Check	HIB Rotateq

		Polio DTaP Prevnar HBV
4 months	Well Baby Check	HIB Rotateq Polio DTaP Prevnar
6 months	Well Baby Check	HIB Rotateq DTaP Prevnar HBV
9 months	Well Baby Check	Hematocrit
12 months	Well Baby Check	MMR HepA VZV
15 months	Well Child Check	DTaP HIB Prevnar
18 Months	Well Child Check	Hep A
2 years	Well Child Check	

Physical exams are also recommended at 30 months and then yearly starting at age three. We recommend it around the birthday.

All children will require a 2nd MMR (measles, mumps, and rubella), DTaP, Chicken Pox and Polio booster at age 4.

At 11 years old Tdap and Menactra are given for all children and Gardasil is recommended for girls **and** boys.

We recommend a blood count once every 2 - 3 years, starting at age 9 months. We suggest cholesterol and triglycerides level at age 5 years, if there is family history of elevated cholesterol and triglycerides or if family members have a history of heart disease or strokes under age 55. We will do more blood work, if your child's history or physical suggests a problem.

Notes

Vaccine Administration Record

VACCINE	Date Given	Age	Parent/Guardian Initials
Hepatitis B 1			
Hepatitis B 2			
Hepatitis B 3			
DTaP 1			
DTaP 2			
DTaP 3			
DTaP 4			
DTaP 5			
TdAP			
HIB 1			
HIB 2			
HIB 3			
HIB 4			
Polio 1			

Polio 2			
Polio 3			
Polio 4			
PCV 1			
PCV 2			
PCV 3			
PCV 4			
Rotavirus 1			
Rotavirus 2			
Rotavirus 3			
MMR 1			
MMR 2			
Varicella 1			
Varicella 2			
Hepatitis A 1			
Hepatitis A 2			
HPV 1			
HPV 2			
HPV 3			
MCV			
Other:			
Other:			
Other:			

FIRST YEAR EXAMINATIONS

Date	Age	Length	Weight	Head Circ	Problems, Diagnoses, Laboratory, and Other Findings

AT REGULAR INTERVALS

Pediatrician's Advice and Comments

SECOND YEAR

Date	Age	Weight	Height	Problems, Diagnoses, Laboratory, and Other Findings

THIRD YEAR

Blood Pressure (Vision, Hearing Optional)

FOURTH YEAR

Blood Pressure, Vision, Hearing

FIFTH YEAR

Blood Pressure, Vision, Hearing, School Readiness

AS PLANNED BY YOUR PEDIATRICIAN

SECOND YEAR

Other Findings	Pediatrician's Advice and Comments

THIRD YEAR

FOURTH YEAR

FIFTH YEAR

EXAMINATIONS – 6TH YEAR ON

Date	Age	Height	Weight	Problems, Diagnoses, Laboratory, and Other Findings

EXAMINATIONS – 6TH YEAR ON

B.P., Vision, Hearing	Pediatrician's Advice and Comments

REFERENCE BOOKS

Caring For Your Baby and Young Child, Editor - Shelov, M.D., Publisher - Bantam books. *Our Favorite*

Child Care, Parent Care, by Marilyn Heins, ML and Anne Seiden, M.D.

How To Parent and How To Father, by Fitzhugh Dodson.

The Mother to Mother Baby Book, Avon Printers

Taking Care of Your Child, by Robert Pontell, M.D.

Crybabies, by Marc Weissbouth, M.D.

Should I Call the Doctor, by Nelson and Pesian.

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www.cdc.gov