Child Health Associates
Boston Children's
Primary Care Alliance

CHILD HEALTH ASSOCIATES P.C.
AUBURN & SHREWSBURY, MA

Parent Survival Guide 2024-2025

105 Millbury Street
Auburn, MA 01501
P: 508-832-9691
F: 508-832-7670

604 Main Street
Shrewsbury, MA 01545
P: 508-842-1500
F: 508-842-7838

www.childhealthassociates.net

Regular Office Hours:

Monday through Friday 9:00 AM – 5:00 PM

Urgent Care Hours in the Auburn Office Only:

We book these hours based on call volume and need

Monday through Friday
Call us by 6 PM to be seen

Saturday and Sunday
Call us by 11 AM to be seen

Did you know:

A Child Health nurse will return your call until 10 PM every night. From 10 p.m. until 8 a.m. a nurse from our on-call service, Night Nurse, will return your call.

A Child Health on-call physician is always available for consultation.

If you call after 4:00 PM. Monday through Friday, all day on Saturday and Sunday or on holidays, you will reach our answering service. Please leave a message and someone from our office will return your call promptly.

EMERGENCIES

Call 911 or go directly to the ER for a life-threatening injury or condition.

Call us for advice 24/7 for:

- a fever in an infant less than 3 months of age
- a head injury with a possible concussion
- wheezing or an asthma flare up
- persistent vomiting
- a simple injury like a sprained ankle

INGESTION

We receive calls, almost daily, about a child who has swallowed some type of toxic household product or medication. Removing poisonous products from a toddler's reach is the best prevention but, if your child ingests anything toxic, call the poison control center IMMEDIATELY.

POISON CONTROL CENTER
1-800-222-1222

TABLE OF CONTENTS

Overview of Office Hours

In Case of Emergency or Ingestion

Table of Contents 1

Child Health Associates Office Information **2**

- Telephone system 2
- Office Hours 2-3
- Booking appointments 4
- Insurance referrals 5
- Billing information 5
- School/Daycare/Camp forms 6

Immunizations **7**
- General Information/Guidelines 7-11
- TB testing (PPD) 11

Well Visit Schedule 12

Developmental Milestones 12

Routine Annual Screenings **13**
- Lead 13
- Anemia 13
- Dental 14

Newborn Information **15**

- General Newborn Care 15-17
- Bowel Movements 18
- Daily Input and Output Log 19
- Jaundice 20
- Rashes 21-22
- Sleep/SIDS 23-24

Car Seats, Belts, and Boosters **25-27**

Flying with Your Child **28**

Healthy Eating and Nutrition **29**

- Milk Guidelines 29
- Juice Guidelines 29
- Feeding Guide for Good Nutrition 30
- Food groups and serving size 31
- Sample Toddler Menu 31
- Calcium Guidelines 32

Common Childhood Illnesses/Injuries **33**

- Abrasions 33
- Burns 33
- Chicken Pox 34
- Conjunctivitis 34
- Cough/Colds 35-38
- Croup 38
- Diarrhea 39
- Dental Emergencies 39
- Ear Infections 40-41
- Fevers 42-43
- Head injuries 44-45
- Head lice 45-46
- Insect Bites/Stings 46-47
- Tick/Lyme disease 48-49
- Poison Ivy 49
- Sore Throats 50
- Sunburns 51
- Teething 52
- Vomiting 52

Parenting Resources **53-56**

Directions **57**

- Child Health Auburn 57
- To UMASS or St Vincent's 57
- Child Health Shrewsbury 58
- To UMASS or St Vincent's 58

Dosing Charts **59**

- Acetaminophen (Tylenol) 59
- Ibuprofen (Motrin, Advil) 59
- Alternating acetaminophen and ibuprofen guidelines 60
- Diphenhydramine (Benadryl) 60

Notes **61**

USING THIS BOOKLET

We appreciate your selecting our office to serve your child's healthcare needs. This booklet is designed to provide information about the office, as well as to present guidelines for proper healthcare, and the growth and development of your child. We hope that you take the opportunity to read this book and familiarize yourself with it. Keep it in a handy place so that you can refer to it as needed. If, after reading about a topic, you feel you need more information, please do not hesitate to contact our office.

ABOUT OUR TELEPHONE SYSTEM

We would like you to be able to call our office and obtain whatever information you require with minimal difficulty. We would like to first explain how our phone system works.

We have receptionists to schedule appointments and nurses to answer medical questions. Our system is computerized, so, if you have a touch tone phone you can select our billing department, referral department, appointment secretaries, and nursing staff with the touch of one number.

On the Nursing/medical advice line nurses schedule sick visits, check laboratory results, give medical advice and obtain information for refilling prescriptions. Medical advice calls can be lengthy please be patient if there is a wait. We realize that waiting on hold can be frustrating, so we work very hard to ensure your call is handled in a timely manner.

Our telephone system is transferred to our answering service at 4:15 PM. If you call after 4:15 PM., or anytime on a weekend or major holiday, your call will be taken by our answering service. Medical personnel do not staff the service, and they cannot give medical advice or make medical judgments. We ask that you limit your calls during after-hours to questions regarding ill children that cannot wait until regular office hours.

If your call to the answering service is urgent, the service should be asked to contact the physician immediately. If it is not an urgent call, the service will contact our office and you should receive a call back from one of our nurses or the physician on call within one hour. If you do not receive a call back within that timeframe, you should call back. It is important to realize that, while we are always available for urgent calls, we are not always in the office.

In a situation where you call the office after hours, on weekends, or on holidays, and the line is continually busy or no one answers, you should assume that our phone lines are out of order. If you have an emergency you should proceed to the UMASS Memorial Medical Center, University Campus Emergency Room at 55 Lake Avenue North Worcester or call 911.

TELEPHONE ADVICE

Many problems do not require an office visit and can be dealt with by phone. Our nurses are highly skilled, knowledgeable professionals and have been thoroughly instructed in our protocol for patient care. They can answer many of your questions over the phone. For a special problem they will consult with the doctor and return your call or have the doctor call you, if needed.

The triage nurses begin taking calls at 8:00 AM during the week and at 7:30 AM on the weekends.

If you are calling the office to schedule a routine well exam, for prescription refills, referrals, or if you have questions about your child that are not illness related, we ask that you call after 11:00 AM Monday through Friday as the early morning hours can be very busy.

REGULAR OFFICE HOURS

The offices are open and fully staffed Monday through Friday from 9:00 AM - 5:00 PM. Well child checkups are generally scheduled between these hours. We are scheduling a year in advance, so please try to anticipate your need for camp, school, and athletic physicals well before any deadlines.

EVENING AND WEEKEND HOURS

Our evening and weekend hours are only booked on an as needed basis for sick/urgent care visits only, these hours are not guaranteed. We have limited appointment availability during this time. Our sick/urgent care hours are intended to address the medical needs of our patients who need immediate care (care that cannot wait until our next regularly scheduled office hours.)

Appointments during any of our sick/urgent care hours will NOT be booked in advance.
Call on Saturday or Sunday morning beginning at 7:30 AM. Appointments are booked in the order calls come in. If you would like your child seen, please call by 11 AM.

MAJOR HOLIDAYS
(Offices are Closed)

NEW YEAR'S DAY	LABOR DAY
THANKSGIVING	MEMORIAL DAY
CHRISTMAS DAY	INDEPENDENCE DAY

MINOR HOLIDAYS
(Walk-in Urgent Care-Auburn office Only)

MARTIN LUTHER KING'S BIRTHDAY	JUNETEENTH
PRESIDENT'S DAY	COLUMBUS DAY
PATRIOT'S DAY	VETERAN'S DAY

On MINOR HOLIDAYS, the office is not open for regular office visits. There is minimal staffing, patients are seen only for urgent care and are booked in the next available appointment time.

APPOINTMENTS FOR ILLNESS

Appointments for sick children are scheduled throughout the day. If your child is extremely ill or in severe pain, please make the office aware of this when you call so that we may schedule the appointment as soon as possible or in some cases direct you to the emergency room. Because these visits are scheduled as "sick visits" the schedules do not allow for lengthy discussions.

If you have ongoing, "non-emergent" issues that you need to discuss, please allow us to book another appointment or to speak with you on the phone at a mutually convenient time. This allows us the opportunity to give adequate time to these important issues. If you feel your child needs to be seen, call the regular office number: (**508) 832-9691** for Auburn or **(508) 842-1500** for Shrewsbury.

It is our policy at Child Health Associates to see a patient in the office before prescribing antibiotics. Due to the increasing frequency of antibiotic resistance, it is important to treat specific bacterial infections with an appropriate antibiotic; **this decision can only be made by examining the patient and cannot be decided over the telephone.**

GENERAL INFORMATION ABOUT APPOINTMENTS

We realize that your time is valuable and that it is inconvenient and irritating to wait for long periods of time to see the doctor. We are continuously working to improve our appointment scheduling to minimize waiting times. We need your help for our schedules to run smoothly.

1. If you are unable to arrive for an appointment on time, please call the office and let us know. We will try our best to accommodate you, but we may have to reschedule your appointment.
2. If you need to cancel an appointment, please call the office 24 hours in advance.
3. If you plan to bring a sibling along to be seen for an illness, please call to obtain an additional appointment for that child. If you call ahead, we can give you an appointment that will allow enough time to appropriately evaluate and treat your child. Parents who arrive with children without a scheduled appointment may be asked to return later in the day as the schedules permit.
4. Upon arrival for your appointment please check in with one of the receptionists. Give us your child's first and last name, date of birth, and the name of the provider that you are scheduled to see.
5. Please present your insurance card and a picture ID and allow our staff to verify your insurance, address, and telephone number each time that you come into our office to ensure that our files remain current.
6. A written, dated consent is required for any child under the age of 18 years to be seen without a legal guardian present.
7. **Under HIPAA regulations, patients 18 years old and over are considered adults and their care cannot be discussed with parents without the consent of the patient. We have forms that the patient can complete granting consent.**

INSURANCE REFERRAL PROCEDURES

Patients who are members of an HMO must obtain approval from their primary care physician before seeing a specialist. Advanced notice of 48 hours is requested for approval, except for emergency room visits. This allows us time to verify and submit the necessary documentation.

When you call our office, please be prepared to provide us with the specialist's first and last name, NPI number, phone and fax number, the date of your appointment, and the reason for the appointment.

Please note that if you arrive at the specialist's office without the necessary authorization, you may be asked to reschedule and/or pay for the visit.

New patients must be seen in our office before a referral can be made to a specialist.

If our office has scheduled a specialist appointment for you, we will also process the insurance referral. You are always welcome to contact our office to ensure that your referral and insurance authorization have been processed.

If you need assistance scheduling an appointment or would like to know which specialists we recommend, please feel free to contact our office to speak with one of our Referral Coordinators.

ER AND URGENT CARE CLINIC REFERRALS

Referrals to the ER or an urgent care clinic, such as ReadyMed, Carewell, Pedi-Q, and Minute Clinic, may be recommended for any child that requires medical attention outside of our normal business hours or if we have no available appointments, depending on the severity of the illness/symptoms.

BILLING PROCEDURES

Please allow us to verify your insurance and address each time that you arrive at our office. If your insurance coverage changes you will need to provide us with a completed insurance form for each child. The form will be kept on file and is good for one year. Billing to a commercial or private health insurance is provided as a courtesy service. All charges incurred that leave any type of balance are the guarantor's responsibility.

All copayments must be paid on the date of service. We are under agreement with our contracted insurers to collect these payments at the time of the visit.

If you are changing health insurance plans or are contemplating changing plans, please feel free to call our billing staff to discuss your options.

CAMP AND SCHOOL FORMS

At your child's annual well visit, we will complete an electronic school form and have it ready for you at the end of the visit. This form is valid for 1 year from the date of the physical and can be used for all school, sports, and camps in Massachusetts.

If a specific form needs to be completed, such as a college form, please ensure that your child is up to date with their annual physical exam (has had one within the last year) and allow us 1-2 weeks to complete the form.

When calling or dropping off a school/camp form, please remember the following:

1. If you request a school form in the office our staff will have you fill out a Form Request. Please fill it out completely and indicate if you would like a call to pick up the form when it is completed, or have it mailed home.
2. **Please note that we will not mail forms or medical records to any other address but the patient's home address.**
3. A MINIMUM of 1 week is required for completion of school forms. Please call us to request a form at least 1 week in advance of the deadline for your child's school, camp, sports etc.

IMMUNIZATIONS

Immunizations are a safe and effective method of protecting the body against certain diseases. The substance given in the vaccine stimulates the body to produce antibodies which fight off specific diseases, thus allowing the body to produce immunity to the disease.

PLEASE NOTE!!

Both the recommended and required vaccine schedules are subject to ongoing review and modification. Child Health Associates practices in accordance with the AAP guidelines. Please feel free to discuss the most recent schedule adjustments with your provider during your child's visit.

In accordance with the guidelines established by the American Academy of Pediatrics, we feel strongly that every child should receive these immunizations.

To protect as many children as possible from these diseases, the state of Massachusetts requires immunizations against diphtheria, tetanus, pertussis, measles, mumps, German measles (rubella), polio, hepatitis B and varicella before entrance to school.

- Babies get six different vaccines between birth and 6 months of age.
- These vaccines protect your baby from 8 serious diseases.
- These vaccines may be given separately.
- Some vaccines might be given together in the same shot (combination vaccines).
    - Pentacel-DTaP, Polio and Hib can be given together.
    - Vaxelis-DTaP, Polio, Hib, and Hepatitis B can be given together.
    - Quadracel-DTaP and Polio can be given together at age 4.
    - Proquad-MMR and Varicella can be given together at age 4.
- These "combination vaccines" are as safe and effective as the individual vaccines and mean fewer shots for your baby. These vaccines may all be given at the same visit. Getting several vaccines at the same time will not harm your child.

VACCINE BENEFITS: WHY GET VACCINATED?

Your children's vaccines protect them from serious diseases, caused by viruses and bacteria. These diseases have injured and killed many children (and adults) over the years.

- Polio paralyzed about 37,000 people and killed about 1,700 each year in the 1950s before there was a vaccine.
- In the 1980s, Hib disease was the leading cause of bacterial meningitis in children under 5 years of age.
- About 15,000 people a year died from diphtheria before there was a vaccine.
- Most children have had at least one rotavirus infection by their 5th birthday in the pre-vaccine era.
- None of these diseases have completely disappeared; without vaccination, they will come back. This has happened in other parts of the world.

HOW VACCINES WORK

Immunity from Disease: When a child gets sick with one of these diseases, the immune system produces immunity, which keeps a child from getting the same disease again.

Immunity from Vaccines: Vaccines are made with the same bacteria or virus that cause the disease, but they have been weakened or killed to make them safe. A child's immune system responds to a vaccine the same way it would if the child had the disease. This means the child will develop immunity without having to get sick first.

DISEASES PREVENTED BY CHILDHOOD AND ADOLESCENT VACCINES

DIPHTHERIA (DTaP and Tdap)-bacterial
You can get it from contact with an infected person. Signs and symptoms include a thick covering in the back of the throat that can make it hard to breathe. It can lead to breathing problems, heart failure, and death.

TETANUS/ Lockjaw (DTaP and Tdap)-bacterial
You can get it from a cut or wound. It does not spread from person to person. Signs and symptoms include painful tightening of the muscles, usually all over the body. It can lead to stiffness of the jaw, so the victim cannot open his mouth or swallow. It leads to death in about 1 person out of 5.

PERTUSSIS /Whooping Cough (DTaP and Tdap)-bacterial
You can get it from contact with an infected person. Signs and symptoms include violent coughing spells that can make it hard for an infant to eat, drink, or breathe. These spells can last for months. It can lead to pneumonia, seizures (jerking and staring spells), brain damage, and death.

HAEMOPHILUS INFLUENZA TYPE B (Hib)-bacterial
You can get it from contact with an infected person. There may be no signs or symptoms in mild cases. It can lead to meningitis (infection of the brain and spinal cord coverings), pneumonia, infections of the blood, joints, bones, and covering of the heart, brain damage, deafness, and death.

HEPATITIS B (Hep B)-viral
You can get it from contact with blood or body fluids of an infected person. Babies can get it at birth if the mother is infected, or through a cut or wound. Adults can get it from unprotected sex, sharing needles, or other exposures to blood. Signs and symptoms include tiredness, diarrhea, vomiting, jaundice (yellow skin or eyes), and pain in muscles, joints, and stomach. If an infant contracts Hepatitis B in the newborn period, they have a 90% chance of having Hepatitis B for life. Chronic Hepatitis B can lead to liver damage, liver cancer, and death.

POLIO (IPV)-viral
You can get it from close contact with an infected person. It enters the body through the mouth. Signs and symptoms can include a cold-like illness or there may be no signs or symptoms at all. It can lead to paralysis (cannot move arm or leg), or death (by paralyzing breathing muscles).

PNEUMOCOCCAL (PCV13 and PPV 23)-bacterial
You can get it from contact with an infected person. Signs and symptoms include fever, chills, cough, and chest pain. It can lead to meningitis (infection of the brain and spinal cord coverings), blood infections, ear infections, pneumonia, deafness, brain damage and death.

ROTAVIRUS (RotaTeq)-viral
You can get it from contact with other children who are infected. Signs and symptoms include severe diarrhea, vomiting and fever. It can lead to dehydration, hospitalization (up to about 70,000 a year), and death.

MEASLES (MMR)-viral
Measles is so contagious that an infected person will spread it to 9-10 unprotected people on average. You can get it from being around someone who has it. Signs and symptoms include rash, cough, runny nose, eye irritation, and fever. It can lead to ear infection, pneumonia, seizures (jerking and staring), brain damage, and death.

MUMPS (MMR)-viral
You can get it from being around someone who has it. Signs and symptoms include fever, headache, and swollen glands. It can lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of testicles/ovaries and rarely, death.

RUBELLA /German Measles (MMR)-viral
You can get it from being around someone who has it. Signs and symptoms include rash, mild fever, and arthritis. If a woman gets rubella while she is pregnant, she could have a miscarriage, or her baby could be born with serious birth defects.

VARICELLA /Chickenpox- viral
You can get it from being around someone who has it, or by contact with fluid from chickenpox blisters. Signs and symptoms include rash, itching, fever, and tiredness. It can lead to pneumonia, encephalitis (infection or inflammation of the brain) and bleeding problems. A person who has had chickenpox can get a painful rash called shingles years later.

HEPATITIS A (Hep A)-viral
You can get it through close personal contact and sometimes by eating food or drinking water containing Hepatitis A virus. Signs and symptoms include "flu-like" illness, jaundice (yellow skin or eyes, dark urine), severe stomach pains and diarrhea.

MENINGOCOCCAL (Menactra and Bexsero)- bacterial
You can get meningococcal disease through close personal contact. It can cause meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. It has a very fast onset and progresses rapidly.

HUMAN PAPILLOMAVIRUS (HPV)-viral
You can get it from direct contact with infected skin. It can lead to cervical cancer in females, vaginal and vulvar cancers in females, anal cancer in females and males, throat cancer in females and males, genital warts in females and males, and penile cancer in males. In the U.S., about 12,000 women get cervical cancer every year, and about 4,000 women die from it. HPV vaccine can prevent most of these cases of cervical cancer. HPV infection usually comes from sexual contact, and most people will become infected at some point in their life. About 14 million Americans, including teens, get infected every year. Most infections will go away on their own and not cause serious problems. But thousands of people get cancer and other diseases from HPV.

INFLUENZA (Flu)-viral
Can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults. Each year thousands of people in the United States die from flu, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

VACCINE RISKS

- Vaccines can cause side effects, like any other medicine.
- Mostly these are mild "local" reactions such as tenderness, redness or swelling where the shot is given, or a mild fever.
    - They happen in up to 1 child out of 4 with most childhood vaccines.
    - They appear soon after the shot is given and go away within a day or two.
- More severe reactions can also occur, but this happens much less often. Some of these reactions are so uncommon that experts cannot tell whether they are caused by vaccines or not.
- Among the most serious reactions to vaccines are severe allergic reactions to a substance in a vaccine. **These reactions happen very rarely – less than once in a million shots.** They usually happen very soon after the shot is given. Doctor's office or clinic staff are trained to deal with them.
- The risk of any vaccine causing serious harm or death, is extremely small. Getting a disease is much more likely to harm a child than getting a vaccine.

OTHER REACTIONS
The following conditions have been associated with routine childhood vaccines. By "associated," we mean that they appear more often in children who have been recently vaccinated than in those who have not. An association does not prove that a vaccine caused a reaction but does mean it is probable.

- **DTaP Vaccine**
    - Mild Problems: Fussiness (up to 1 child in 3), tiredness or poor appetite (up to 1 child in 10), vomiting (up to 1 child in 50), swelling of the entire arm or leg for 1-7 days (up to 1 child in 30) – usually after the 4th or 5th dose.
    - Moderate Problems: Seizure (jerking or staring - 1 child in 14,000), non-stop crying for 3 hours or more (up to 1 child in 1,000), fever over 105°F (1 child in 16,000).
    - Serious Problems: Long-term seizures, coma, lowered consciousness, and permanent brain damage have been reported **very rarely** after DTaP vaccine. They are so rare we cannot be sure they are caused by the vaccine.
- **Polio Vaccine / Hepatitis B Vaccine / Hib Vaccine**
    - These vaccines have not been associated with problems other than local reactions.
- **Pneumococcal Vaccine**
    - Mild Problems: During studies of the vaccine, some children became fussy, drowsy, or lost their appetite.
- **Rotavirus Vaccine**
    - Mild Problems: Children who get rotavirus vaccine are slightly more likely than other children to be irritable or to have mild, temporary diarrhea or vomiting. This happens within the first week

after getting a dose of vaccine. Rotavirus vaccine does not appear to cause any serious side effects. Rotavirus is an oral (swallowed) vaccine, not a shot.

- **Meningococcal Vaccine**
    - A small percentage of people who receive meningococcal vaccine experience muscle or joint pains.

- **HPV Vaccine**
    - Reactions in the arm where the shot was given:
        - Soreness (about 9 people in 10).
        - Redness or swelling (about 1 person in 3).
    - Fever: Mild (100°F) (about 1 person in 10).
        - Moderate (102°F) (about 1 person in 65).
    - Headache (about 1 person in 3).

- **Influenza (Flu) Vaccine**
    - **S**oreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
    - There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

PRECAUTIONS- special circumstances

- If your child is sick on the date vaccinations are scheduled, your provider may want to put them off until she recovers.
- A child with a mild cold or a low fever can usually be vaccinated that day. But for a more serious illness, it may be better to wait.
- Some children should not get certain vaccines. Talk with your provider if your child had a serious reaction after a previous dose of a vaccine or has any life-threatening allergies. (These reactions and allergies are rare.)
- Talk to your provider before getting **DTaP** vaccine if your child had any of these reactions to a previous dose of **DTaP:**
    - A brain or nervous system disease within 7 days.
    - Non-stop crying for 3 or more hours.
    - A seizure or collapse.
    - A fever over 105°F.
- Talk to your provider before getting **Polio** vaccine if your child has:
    - A life-threatening allergy to the following antibiotics: neomycin, streptomycin, or polymyxin B.
- Talk to your provider before getting **Hepatitis B** vaccine if your child has:
    - A life-threatening allergy to yeast.
- Talk to your provider before getting **Rotavirus** vaccine if your child has:
    - A weakened immune system.
    - Ongoing digestive problems.
    - Recently gotten a blood transfusion or other blood product.
    - Ever had intussusception (an uncommon type of intestinal obstruction).
- Talk to your provider before getting the **Varicella** vaccine if your child has:
    - A gelatin allergy.

WHAT SHOULD I LOOK FOR?

Look for any unusual condition such as: a serious allergic reaction, high fever, weakness, or unusual behavior. Serious allergic reactions are extremely rare with any vaccine. If one were to happen, it would most likely come within a few minutes to a few hours after the shot.

IF YOUR CHILD HAS A SIGNIFICANT VACCINE REACTION

If there is a moderate or severe reaction, you should look for any unusual condition such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness, wheezing, swelling of the throat, hives, paleness, weakness, a fast heartbeat, or dizziness. ***CALL 911 IMMEDIATELY if your child experiences these symptoms***.

Report the reaction to your doctor including: the date and time it happened as well as when the vaccine was given. Ask your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

ALL VACCINE INFORMATION SOURCED FROM www.cdc.gov/vaccines

T.B. TEST (TUBERCULIN or PPD TEST) or QuantiFERON Gold testing

We utilize a TB (tuberculosis) risk screening questionnaire to determine whether your child has any risk which may increase his/her likelihood of exposure to TB. If your child is at increased risk, a PPD test may be administered. A PPD is a screening test that is done to determine if the child has ever been exposed to tuberculosis. The test is repeated at variable intervals depending on the risk of exposure.

QuantiFERON Gold testing is a blood test that may be used in place of the PPD for patients over the age of 5 that have had BCG in the past.

WELL VISIT SCHEDULE

Routine well visits are recommended and scheduled based on the AAP guidelines. Well visits include but are not limited to monitoring growth and development, providing guidance for your child's healthcare needs, administration of vaccines, discussing parental and child concerns, and discussing preventative care. The CHA schedule of well visits:

- 1st newborn visit (typically before 1 week of age).
- 2 weeks, 6 weeks, 4 months, 6 months, 9 months, 12 months, 14 months, 18 months.
- Then annually beginning at age 2 through college.

DEVELOPMENTAL MILESTONES

Children are always learning new things. These are just some of the things you should be looking for as your child grows. Since every child develops at his or her own pace, your child may reach these milestones slightly before or after other children the same age. Use this as a guide, and if you have any concerns, talk with your child's doctor or nurse.

2 Months

- Makes jerky, quivering arm thrusts.
- Turns head from side to side when lying on stomach.
- Startles to loud sounds.
- Quiets in response to voice.
- Eyes wander and occasionally cross.

4 months

- Turns head in response to human voice.
- Rolls from side to side.
- Raises head and chest when lying on stomach, sits with support.
- Brings hands to mouth, grasps/shakes hand toys.
- Increased babbling/imitating sounds.
- Smiles spontaneously.

6 months

- Uses 'raking' grasp, transfers object from hand to hand.
- Begins to sit independently, supports whole weight on legs.
- Improvement in visually tracking moving objects.
- Increased repetitive babbling.
- Laughs.

9 months

- Supports weight standing, pulls to stand.
- Sits alone well, may crawl.
- Respond when told "no."
- Uses nonspecific "mama" and "dada."
- Understands simple commands.

12 months

- Turns head to own name.
- Imitates action in their play, imitates gestures.
- Walks with one hand being held, stands momentarily.
- Picks up objects with pincer grasp.
- Shy or anxious with strangers, cries when parent leaves.

18 months

- Drinks from cup with little spilling.
- Uses several single words, babbling is sentence-like.
- Understands new words weekly.
- Walks well independently.
- Knows the function of common household objects.

24 months (2 years)

- Begins to run, kicks ball, throws overhand.
- Points to familiar objects and body parts when named.
- Uses simple phrases, uses 2-4-word sentences.
- Enthusiastic about the company of other children.
- Vocabulary increases dramatically.

36 months (3 years)

- Can help tell a simple story, answers questions.
- Walks upstairs alternating feet.
- Cooperates with other children.
- Increasingly inventive in fantasy/make-believe play.
- Begins to recognize and correctly name colors.

48 months (4 years)

- Tells stories, speaks clearly enough for strangers to understand.
- Uses 6-word sentences.
- Dresses self.
- Runs smoothly, hops on one foot.
- Goes up and down stairs without support.

Questions to ask your child's doctor or nurse

- What can I do to keep track of my child's development?
- What should I do if I am worried about my child's progress?
- Where can I go to get more information?
- Can you refer me to a specialist for more information?

From Burns, C.E., Dunn, A. M., Brady, M.A., Starr, N.B., Blosser, C.G. (2009). *Pediatric Primary Care* (4th ed.). St. Louis, Mo: Saunders Elsevier

American Academy of Pediatrics. (2011). Ages and Stages: Developmental Milestones. Retrieved from http://www.healthychildren.org/English/ages-stages/Pages/default.aspx

LEAD POISONING PREVENTION

Annual lead screening is required by Massachusetts States Law on children 9 months through 3 or 4 years of age, depending on your town of residence. Some children need more frequent screening because they are more likely to be exposed to lead. The test involves a fingerstick blood sample which is drawn and run in our office. The test results are generally available in 72 hours.

Several conditions increase the possibility of lead exposure:

1. Living in housing built before 1978 which has chipping paint or broken plaster.
2. Living in housing built before 1978 which is undergoing renovations.
3. Living near lead smelting plants or having family members who work with lead.
4. Living in housing which contains lead pipes or using dishes, crystal or pots which contain lead.
5. Products from overseas such as: jewelry, toys, spices, and home remedies/medications.

ANEMIA SCREENING

A finger-stick blood test for anemia (low iron) is obtained in our office at 9 months of age and is repeated at varying ages. The most common cause of anemia in children is iron deficiency. To prevent this, we recommend that you use a high iron formula (if formula feeding) and iron-fortified cereals. After 12 months of age limit the daily intake of whole milk to 16-24 ounces per day.

Foods that are rich in iron and should be encouraged include:

Meats	Beef, pork, veal, liver, or liverwurst. Chicken, turkey, fish, and eggs have some iron but do not have as much as liver and red meats.
Beans	Baked beans made with molasses are especially high in iron; lima beans and navy beans; Chili made with red kidney beans; peas and lentils.
Vegetables	Beets, spinach, broccoli, brussel sprouts, chard. In general, deeply colored vegetables have more iron than lightly colored ones.
Fruits	Dried Fruits: Raisins, apricots, prunes, peaches. Juice: prune juice, orange juice helps your body utilize iron, as do other food and juices high in Vitamin C.
Bread/Cereal	Whole-grain bread, iron fortified bread and cereal; iron enriched pasta; rice enriched with iron. (Minute Rice does not have iron). Total, Special K, Wheat Chex, Rice Chex, Cream of Wheat (add raisins and brown sugar for extra iron), Maltex, All Bran cereals, especially Bran Flakes with Raisins, Oatmeal. Sugared cereals are low in iron as well as other nutrients and are not recommended.

If your child is anemic, an iron supplement may be prescribed by your physician. There are certain instructions of which you should be aware.

1. Always give iron mixed in juice that does not contain calcium, or a non-dairy food. If given alone, it can temporarily stain the teeth black. If mixed with milk or a milk product the iron may not be well absorbed.
2. **IRON CAN BE POISONOUS** if taken in large quantities. Be careful to keep out of the reach of children. **Call Poison Control immediately if your child accidentally ingests the iron supplement.**
3. Your child's iron test must be repeated following iron treatment before you discontinue the iron supplement. The nurse will tell you when to return for a blood test**. GIVE THE IRON UNTIL YOU ARE INSTRUCTED TO STOP**, not when the bottle runs out!
4. Iron may turn the bowel movements black (or dark). It may also cause constipation and you should increase the amount of fruit and water your child takes when you start the iron.

DENTAL CARE

According to the American Academy of Pediatrics, your child's first visit to the dentist should between 12-18 months of age. Until then, brush your child's teeth twice daily with a small amount of **fluoride-free** toothpaste.

A fluoride supplement is recommended for children who live in an area where fluoride is not present in the water.

Putting a baby to bed with a bottle, whether for a nap or at night, is **not recommended** because the bottle can cause dental decay as milk pools around the teeth and creates a breeding ground for decay. Exclusive use of a cup after 15-18 months is recommended.

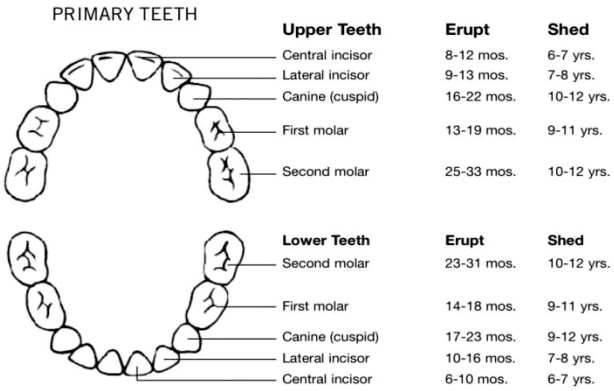

Chart from twinklelittlestardentistry.com

NEWBORN INFORMATION

Vitamin D
Breastfed babies require a Vitamin D supplement. Not enough Vitamin D transfers from breastmilk to the infant. Buy Vitamin D (a liquid) over the counter in the aisle where children's vitamins are sold. Give Vitamin D every day to help with bone development.

Circumcision Care
If your child has been circumcised, you should put a piece of gauze with Vaseline over the circumcision with each diaper change for a week to 10 days, until the tip of the penis is a light pink color. As the circumcision heals, it often develops a yellow film over the tip (especially on the underside) – this is a normal part of the healing process, it does not indicate an infection. Leave this film alone, it will go away on its own.

Vaginal Discharge in Newborns
Female babies can have a vaginal discharge for the first 1-2 weeks. This is a normal after-effect of mother's hormones on baby's body. The discharge can be clear, white or it can even have blood mixed in – this is all normal.

Umbilical Cord Care
You should continue to clean the umbilical cord according to the instructions given to you in the nursery (3-4 times a day). It is likely that your baby's umbilical cord was painted with a blue dye that is used to prevent infection (that is why it looks dark). Before the dye was applied, the umbilical cord was yellow. The dye does not reach all the way down to where the umbilical cord is attached in the belly button, as the cord starts to detach, you may see some yellow where it is attached. This is normal, it is not infected. If the skin outside the belly button looks red or puffy like a sunburn, call the office. It takes 2-3 weeks for the cord to fall off. Until that time, you should sponge bathe your baby; do not immerse the cord in water. The cord can bleed as it starts to separate, this is normal if it is not soaking through layers of clothing.

Dry Skin
It is normal for your baby to have dry, peeling skin over the first few weeks; it is a function of coming from a liquid (amniotic fluid) to a dry environment. You do not have to put anything on the dry skin.

Wet Diapers
In 24 hours, your baby should have the same number of wet diapers as days old that they are. If your baby is 4 days old, expect 4 wet diapers. They will hit a maximum of 6-8 wet diapers a day (maybe more).

Baths
Babies do not need to be bathed frequently. You want to make sure that you clean their neck daily (milk/formula can collect in neck folds). You only need to give them a regular bath 1-2 times a week.

Honey
Children under the age of 12 months should not be given honey.

Emergency Room
If you feel that you need to take your child to an ER or the office directs you to the ER, go the University Campus of UMass which has a 24-hour Pediatric Emergency Room (55 Lake Avenue North, Worcester).

Contacting the Office
The office can be reached 24 hours a day by calling 508-832-9691. In the evening, an answering service will take your name and number and then a nurse or doctor will call you back.

The Newborn Look
All newborns are beautiful, but they do show signs of the trauma of birth. Your new baby's eyes might look puffy. Swelling may result from pressure on the face during delivery or from the drops placed in your baby's eyes at birth to prevent infection. These signs will all disappear in a few short weeks (as will the bent ears, skin rashes, pointed heads and flat noses.

Newborn ears are commonly floppy and soft. One of the edges may be folded over. The outer ear will return to normal shape over the first few weeks of life as the cartilage hardens. The newborn nose can become misshapen during the birth process. It may be pushed to one side or flattened but will look normal by 1 week of age.

How your newborn sees the world
A newborn can make out blurry faces at birth, even through swollen eyelids. You may notice your baby blinking or squinting. These are newborn habits that will soon go away naturally. A newborn baby focuses best on objects about 12 inches away. They will look to the right and left rather than straight ahead and enjoy looking at faces and black-and-white patterns. Infants seem happier in a well-lit room.

Listening to Mom and Dad
Babies first hear the world while still inside their mothers. They may already be used to familiar sounds when they are born and sleep right through them. Newborns react to loud noise by startling. Watch how your baby responds to your voice, and to singing or music. If he or she never responds, talk to your pediatrician.

HOW TO CARE FOR YOUR BABY'S PRECIOUS EYES

Normal eye discharge
Many newborn's eyes have a crusty, yellow discharge that goes away by the fifth day. This is not an infection. It is a reaction to the drops used at birth to prevent eye disease.
If the swelling and discharge do not clear up, or if they begin **after** the first 24 hours, they may be caused by an infection or a blocked tear duct. Call your doctor for advice.

Protect eyes from damage
As your baby grows, eye exams should be part of the well-baby exams. Keep your baby away from pointed objects and blowing dust. *Remove particles in the eye by pulling the upper eyelid out and down over the lower lid. Flush the eye with water. Do not rub your baby's eye.* If you cannot remove a particle, if your baby's eyes are injured in any way or if there is discharge, swelling or redness, call your pediatrician.

WAYS TO CARE FOR YOUR BABY'S HEARING

Guard sensitive ears
Never put anything in your baby's ears, not even a cotton swab.
Wipe the outer ears with a washcloth or cotton ball. Your baby's ears will clean themselves naturally. *If something has gotten into the ear, turn the baby so the ear faces down and move the head very gently, so it falls out.* If this does not work, call your pediatrician.

Watch for signs of infection
Newborns are rarely found to have ear infections. If your baby is extra fussy, seems to have pain when swallowing, or is running a fever, call your pediatrician. Talk to your doctor or one of our triage nurses before giving your newborn any medications.

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BABY'S BATH TIME

Keeping your baby clean
Until your baby starts crawling, they will not get very dirty. You will not need to bathe them every day. A wet washcloth here or there will keep him/her clean where he/she does get dirty, on his/her bottom, face, hands, neck, and skin creases. You should wash the diaper area from front to back every time you change a diaper.

Giving your newborn a sponge bath
Until your baby's umbilical cord drops off, give a sponge bath instead of a tub bath. You will need a warm room, a bowl of warm water and a thick towel to put the baby on. Some babies love the feeling of being undressed and cry when you dress them. Others cry if they are undressed, so it may be better to undress and bathe your baby a little at a time, starting with the chest and arms, then legs and so on.

Caring for baby's cord
You will need to keep the stump of the umbilical cord clean and dry as it shrivels and eventually falls off. Keep the diaper folded below the cord to keep urine from soaking it.

You may notice a few drops of blood on the diaper around the time the stump falls off; this is normal. I**f the cord does actively bleed, call your baby's doctor immediately**. If the stump becomes infected, it will require medical treatment. Although an infection is quite uncommon, contact your doctor if any of these signs are present:

- Foul-smelling yellowish discharge from the cord.
- Red skin around the base of the cord.

The umbilical cord stump should dry up and fall off by the time your baby is six weeks old. If it remains beyond that time, there may be other issues. See the baby's doctor if the cord has not dried up and fallen off by the time the baby is two months old.

HOW TO KEEP BABY'S BATH TIME SAFE

Get organized
Keep all your supplies together and put them by the bathtub before you undress your baby. You will need mild soap, tearless baby shampoo, a washcloth, cotton swabs to clean the umbilical cord, a large towel or receiving blanket, a towel to line the tub or sink, clothing, and diapers.

Fill the Tub
The hot water heater should be set to no more than 120 degrees Fahrenheit. Fill the bath and test the water temperature with your elbows or inside wrists. Run the cold water last so if your baby touches the faucet, it will not burn. Undress your baby and wrap your baby in a towel.

Never leave your baby alone
Never leave a baby alone in the bath, even for an instant. Your baby is never safe in her bath without you, no matter how little water there is in the tub. If the phone or doorbell rings, wrap the baby in a towel, soap and all and take them with you. If there is a real emergency, put your baby on the floor. The baby cannot fall or drown there.

Whether you choose to bathe your baby in a sink, bathtub, infant tub or shower, here are some practical principles that are common to all:

- **Handle with care**
  - You will find it easiest to use your non-dominant arm and hand to support your baby's head and back as needed. (i.e., Use your left hand for support if you are right-handed.) Reach behind/under your baby and hold on to their opposite arm throughout the bath, ensuring they will have unwavering support while you still have your preferred hand free for cleaning.
- Eyes – Wipe eyes from inside to outside, using a new part of the washcloth for each eye.
- Face – Gently wipe your baby's face with a clean, damp cloth.
- Ears – Never put anything in your baby's ears, not even a cotton swab. Wipe the outside and behind the ears with the corner of a damp washcloth.
- Nose – Use the corner of a damp washcloth to soften and remove dried mucus.
- **Start at the top**
  - Working from the top down, it helps keep areas that were already rinsed clean from getting soapy again.
  - If your baby has any hair and you think it needs washing, add a small amount of all-purpose baby wash or shampoo to your palm or a washcloth and rub it into your baby's hair. When rinsing, simply tilt your baby's head back slightly to avoid getting soap or shampoo into the eyes or ears. Rinse well and pat dry. Comb her head, even if it is almost bald, to prevent scaling.
- Remember to lift and separate any folds as best you can, including those in your baby's neck, armpits, and groin.
- If you are going to use a mild soap or baby wash, put a small amount on the washcloth or your hand and gently rub it onto your baby's body from the neck down. For safety's sake, we highly recommend keeping your holding hand soap free to prevent a slippery situation. If you get soap on the baby's hands, make sure to rinse them quickly before your baby tries to rub their eyes or chew on their fingers.
- **There is no hands-free option.** For safety's sake, always keep at least one hand, and both eyes, on your baby at all times.
- Chat and smile while you bathe your baby. This is also a good time for a gentle massage.
- Wrap your baby in a towel and dry them completely, even the skin creases.

BOWEL MOVEMENTS

There is great variation in number, color, and consistency of stool in infants and young children. Beginning with the first day of life and lasting for a few days, your baby will have his or her first bowel movements which are often referred to as meconium. This thick black or dark-green substance filled the intestines before birth, and once the meconium is passed, the stools will turn yellow green.

If your baby is breastfed, the stools should soon resemble light mustard with seed-like particles. The consistency of the stools may range from very soft to loose and runny, until the baby starts with solid foods. If the baby is formula-fed, stools will usually be tan or yellow in color. They will be firmer than in a breastfed baby, but no firmer than peanut butter.

Breastfed babies will commonly have 6-8 liquidy stools a day but may have up to 30; formula-fed babies generally have fewer stools. Bowel movement frequency varies widely from one baby to another. Many pass a stool soon after each feeding. This is a result of the gastrocolic reflex, which causes the digestive system to become active when the stomach is filled with food.

By 3-6 weeks of age, some breastfed babies have only one stool a week and are still normal. Breastmilk leaves very little solid waste to be eliminated from the child's digestive system. Thus, infrequent stools are not a sign of constipation and should not be considered a problem if stools are soft (no firmer than peanut butter), and the baby is otherwise normal, gaining weight steadily, and nursing regularly.

If your baby is formula-fed, he or she should have at least one stool a day. If your baby has fewer than this **and** appears to be straining because of hard stools, they may be constipated. Constipation is the passage of hard, formed stools, it has nothing to do with the frequency of stools. If you think your child might be constipated, call your pediatrician for advice.

Stools can vary in color from yellow, to green to light brown. Call the office if you notice bright red blood, mucus, black, or white bowel movements.

Toddlers and other children may temporarily become irregular when their diet or schedule is interrupted, such as during an illness. Children with persistent or recurrent constipation should be given a diet high in fiber and fruits such as plums, pears, peaches, prunes, raisins, and grapes. Prune juice can also be used. Foods such as those mentioned above also help to prevent constipation.

BREASTFEEDING INTAKE AND OUTPUT

How can you tell if your baby is getting enough breastmilk?

Signs your baby is getting enough milk

- Your baby's cheeks stay rounded, not hollow during sucking. They seem calm and relaxed during feeds. Your baby comes off the breast on their own at the end of feeds. Their mouth looks moist after feeds.

Keeping a daily Intake and Output log can help guide you. See the Daily Intake and Output Log on page 19.

Expected intake and output

- Feedings: 8-12 each day
- Wet diapers: Day 1 one, Day two 2, Day 3 three, Day 4 and after six
- Stools: 2 to 3 each day

Daily Intake and Output Log

Name _____ Day _____ Date _____

	Direct feeding		Supplement		Output		Milk expression	
Time	**Minutes R/L**	**Quality***	**Type**	**Amount**	**Wet****	**Stool *****	**Minutes**	**Amount**

Expected intake and output

Feedings: 8 to 12 each day

Wet diapers: Day 1 one, day 2 two, day 3 three, day 4 and on six

Stools: 2 to 3 each day

Contact your baby's health care provider and/or lactation consultant if you baby does not meet these minimums. Or if, during the first week of life, baby does not stool in 24 hours.

*Estimate quality of feeding: poor, good, very good.

**Estimate amount of urine: damp, wet, soaked.

***Estimate amount of stool: smear, medium, large.

JAUNDICE

Jaundice is a common condition in newborn infants that usually shows up shortly after birth. In most cases, it goes away on its own. If not, it can be easily treated.

What is Jaundice?
A baby has jaundice when bilirubin, which is produced naturally in the body, builds up faster than a newborn's liver can break it down and get rid of it in the baby's stool. This happens because of one or more of the following reasons:

- The baby's developing liver is not yet able to remove the bilirubin from the blood.
- More bilirubin is being made than the liver can manage
- Too much of the bilirubin is reabsorbed from the intestines before the baby gets rid of it in the stool

Too much bilirubin makes a baby's skin look yellow. This yellow color will appear first on the face, then on the chest and stomach, and finally, on the legs.

What is bilirubin?

- Everyone's blood contains hemoglobin found in red blood cells. Red blood cells live only a short time and, as they die, the oxygen-carrying substance (hemoglobin) is changed to yellow bilirubin.
- Normal newborns have more bilirubin because their liver is not efficient at removing it. Older babies, children, and adults get rid of this yellow blood product quickly, usually through a bowel movement.

Can jaundice hurt my baby?

- Jaundice can be dangerous if the bilirubin reaches too high a level in the blood. The level at which it becomes dangerous will vary based on the child's age and if there are other medical conditions. A small sample of your baby's blood can be tested to measure the bilirubin level. Other tests may be needed to see if your baby has a special reason to make extra bilirubin that is causing the jaundice.

How do I know if my baby has jaundice?

- Parents should be aware of any changes in their newborn's skin color or the coloring in the whites of their child's eyes. Look at the baby under natural daylight or in a room that has fluorescent lights.
- A quick and easy way to test for jaundice is to press gently with your fingertip on the tip of your child's nose or forehead. If the skin looks white (this is true for babies of all races), there is no jaundice. If you see a yellowish color, contact your pediatrician to check your baby to see if significant jaundice is present.
- Jaundice starts in the face and spreads downward; it clears from the bottom up.

How is jaundice treated?

- Mild to moderate levels of jaundice do not require any treatment. If high levels of bilirubin do not clear up on their own, your baby may be treated with special lights or other treatments. These special lights help by altering the bilirubin to make it easier for your baby's liver to get rid of it. This treatment requires your baby to stay in the hospital for a few days. If your baby needs light therapy, talk to your pediatrician about how long the treatment lasts and where it will be done.

What effects does breastfeeding have on jaundice?

- Most breastfed babies do not have a problem with jaundice that requires interruption of breastfeeding. However, if your baby develops jaundice that lasts one week or more, your pediatrician may ask you to temporarily stop breastfeeding for a day or two. If you must temporarily stop breastfeeding, talk to your pediatrician about pumping your breasts so you can keep producing breast milk and can restart nursing easily.
- If your baby has jaundice, do not be alarmed. Remember that jaundice in a healthy newborn is not serious and usually clears up easily. If your baby has a very serious case of jaundice and other medical problems, your pediatrician will talk to you about other treatments.

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

RASHES

We could easily devote a whole guidebook about rashes. Infants may develop rashes shortly after birth and may be "rashy" at any time during childhood. Please keep in mind that most infant and childhood rashes do not bother children. **Most rashes do not constitute an emergency and can be dealt with during office hours.**

Milia and Baby Acne

- Many babies are born with milia, which are pearly white bumps on the nose, chin or cheeks caused by skin flakes trapped near the surface of the skin. Milia usually clears up on its own, usually within a few weeks.
- More than 30% of newborns develop small red bumps on the face. Infant acne, as it is known, can begin as early as 3-5 weeks of age and last until 5-6 months of age. The cause seems to be the transfer of maternal hormones prior to birth.
- For babies with milia or baby acne, simply wash with water and mild baby soap daily. Avoid lotions or oils, and never scrub, pinch, or pick at the bumps. If baby acne does not clear up within three months, if significant irritation or pain is present, please call the office.

Cradle Cap

- Cradle cap is dry, crusty, flaky, or greasy, scaly patches of skin found on top of a newborn's head. Cradle cap is found most often in newborns and is not contagious. It usually clears up on its own.
- Cradle cap may be treated by shampooing your baby's hair daily with a mild baby shampoo. You can loosen the scales with a soft-bristle brush before rinsing. If the scales are stubborn, use a few drops of mineral oil and rub into the scalp, let sit, and then brush and shampoo your baby's hair. If cradle cap persists, contact your pediatrician.

Diaper rash

- Diaper rash occurs most often between 8-10 months when babies start to eat solid foods and affects more than half of all infants. Causes of diaper rash include prolonged contact with urine or stool, chafing, reaction to diaper material or yeast infections (sometimes caused by antibiotics.)
- To prevent diaper rash, change soiled diapers promptly.
  Clean your baby's bottom with gentle baby wipes or use a squirt bottle of water to keep from rubbing too much. Pat the area dry and consider applying a small amount of petroleum jelly. Only use soap when the stool will not come off easily. Avoid using rubber pants over the diaper and keep the diaper loose (but not too loose) especially at night.
- Treat diaper rash by applying a thick layer of zinc oxide, triple paste or petroleum and expose your baby's bottom to air as much as possible. If you notice any bleeding, pus-filled sore or if the rash does not go away within 48-72 hours, notify your pediatrician.
- Diaper rash can also be caused by yeast infections. This appears as a bright red rash, possibly with red dots, either in the diaper area or anywhere your baby's skin touches other skin. There may also be superficial peeling of the skin in the diaper area. Yeast rashes may be accompanied by thrush (white patches inside the cheeks and lips.)
- A yeast rash may be treated with clotrimazole cream (Lotrimin cream - over the counter) three times daily. If the rash is not clearing within 2-3 days or if it is worsening, call the office during office hours.
- If your baby is in cloth diapers, adding 1 cup of vinegar to the final rinse may reduce the chance of yeast in the diaper area.

Remember:

- Diaper rashes are commonplace and usually cause little discomfort.
- Change diapers frequently, cleaning the diaper area with each change.
- It is not necessary to use ointments or creams on rash-free diaper areas.
- Powder is not recommended for use in the diaper area.

Dry skin rashes

- Many infants and children have dry skin. Some kids have dry skin year-round, but we tend to see more of it in the winter months. Dry skin is often difficult to see, but you can feel the roughness. Sometimes you may notice flesh colored “pimples” on the arms and legs which have a rough, sandpaper feel when rubbed with your hand. Often you will observe “patches” of dry skin which are raised and “scaly.” These patches are sometimes confused with ringworm.
- Dry skin may cause little, if any discomfort, or the child may be quite uncomfortable and itchy.
- There are several things to consider when caring for dry skin.
    - Avoid using bleaches and fabric softeners.
    - Over-bathing dries the skin more than less bathing. Bathing every second or third day will often suffice. Frequent, shorter baths (less than 10 minutes) are preferable to longer baths. Oatmeal baths can be soothing for dry skin and itching.
- Use unscented Dove, Aveeno, or Neutrogena soaps; try to avoid Ivory soap (it is drying). To help lubricate the skin we usually recommend Aquaphor, Vaseline, Eucerin or a similar cream. Applying moisturizer within 3 minutes of getting out of the bath/shower can maximize absorption.
- Wintertime exacerbates dry skin. Indoor heat tends to be drying; we suggest increasing the humidity in your indoor environment by using a humidifier or vaporizer.
- If dry skin problems make your child uncomfortable due to itching or cracking, irritated of weeping patches of skin, please call your pediatrician.

SLEEP

- Please remember that there is infinite variability in sleep patterns in infants and children. Some infants will sleep through the night at an average age of 2-4 months, while many others will continue to wake at night for years.
- These changeable sleep patterns are as varied as everyone's personality, looks, size, etc. For the most part, whether a baby wakes at night is unrelated to breast feeding vs. bottle feeding or solids vs. liquid feeding.
- High energy babies and toddlers will require less sleep and may severely disrupt other siblings and parents with nighttime crying. How you manage this depends on your own style and situation. Resist bringing the child into bed with you or handing a bottle to the child in bed. Sometimes a firm reassuring voice or a pat on the back, a night light, or a radio, will suffice. More stubborn children will hold out for more attention. A baby should not be expected to self-soothe until 4-6 months of age.
- Keep in mind that disruptive sleep patterns in infants and preschool age children are common and only temporary.

(Please refer to our suggested reading list on page 46)

Basic sleep-related milestones

- **Daily sleep**
  The average newborn spends at least 16 hours a day sleeping but there can be big differences from one newborn to the next.

  The total amount of sleep babies need in any given 24-hour day gradually decreases over time, but still totals just over 14 hours at 6 months of age and just under 14 hours at 1 year.

- **Naps**
  The length of most newborn naps can vary, and they tend to be scattered throughout the day (and night) in a completely random and therefore unpredictable manner. Many newborns nap in 1- to 2-hour spurts. Most newborns do not settle into the 3-nap-a-day schedule for at least a month or two. Even then, it can take a few additional weeks or months before you can count on a morning, early afternoon, and early evening nap.

- **Night versus da**y
  During the first few days and weeks after birth, it will be almost completely up to your newborn when he or she chooses to be awake and when they choose to sleep.

  Most newborns spend equal amounts of time sleeping during the day and night. This can be challenging for those parents accustomed to an awake-by-day, asleep-by-night approach.

  By the end of the first month, most newborns do figure out how to consolidate their sleep into longer stretches and start to get at least one extended stretch of sleep each 24-hour day. Making middle of the night feedings boring (minimizing interaction) can help encourage longer sleep stretches at night.

  By 3 months of age, many babies get approximately two-thirds of their total daily sleep during the night.

  Babies do not have regular sleep cycles until about 6 months of age. While newborns sleep about 16 to 17 hours per day, they may only sleep 1 or 2 hours at a time.

  As babies get older, they need less sleep. However, different babies have different sleep needs. It is normal for a 6-month-old to wake up during the night but go back to sleep after a few minutes.

For the most part, the following concerns cause parents to worry unnecessarily:

- **Spitting up and vomiting**
  The most common concern is the understandable but unfounded fear that babies will spit-up and choke while on their backs.

  Several reassuring studies as well as the test of time have demonstrated that healthy babies put to sleep on their backs are not only able to turn their heads and/or protect their airways if and when they spit up but are no more likely to have breathing or digestive-related problems than their belly-sleeping counterparts of years past.

- **Flat heads**
  It is true that the shape of your newborn's head is not yet set-in stone, and that there has been an increase in the number of babies "walking" around with flat heads since back sleeping has been recommended.

  The fact of the matter is, it is not that much of a problem for most back-sleeping babies because you have a good deal of control over the situation. All you need to do is alternate the direction your baby faces each time they lie on their back both while they are asleep and when awake.

  Babies often prefer to look towards their parents' bed when sleeping in their parents' room. If you alternate the location their head points to (toward your head vs feet) they will turn naturally toward you.

  By offering your newborn plenty of tummy time and time spent in positions other than flat on their back while they are awake, you can also help decrease the likelihood of a flat or misshapen head.

- **Delayed milestones**
  In addressing the question of delayed milestones—or more specifically, a delay in the time when back-sleeping babies first begin to roll over—rest assured that this all seems to even out in the end.

  When it comes to strengthening the muscles which your baby needs to roll and decreasing your baby's chances of ending up with a flat head, just be aware that both can be easily accomplished by allowing your baby plenty of time on the belly when awake.

Please note that the above suggestions apply to healthy babies who are free from neurological or developmental issues. Please feel free to discuss sleep positions with your provider.

PROTECTING YOUR INFANT FROM SIDS AND OTHER CAUSES OF SLEEP-RELATED DEATHS

The American Academy of Pediatrics makes the following recommendations to parents and caregivers to provide a safe sleeping environment for infants and to reduce the risks of death from sudden infant death syndrome (SIDS), suffocation or entrapment while sleeping.

- All infants should be placed on their backs to sleep until 1 year of age unless, in rare cases, directed to do otherwise by a pediatrician. There is no evidence that infants with reflux are at an increased risk of choking while sleeping on their backs. In addition, once infants can roll from their back to their stomach, they can remain in the sleep position they choose but still should be placed to sleep on their backs.
- Place the baby to sleep on a firm, flat mattress with only a fitted sheet. Adult beds or soft mattresses increase the risk of suffocation.
- Car safety seats, strollers, swings, rock and plays, infant carriers and infant slings should not be used for routine sleep because they can put infants in a position that places them at risk for suffocation or airway obstruction.
- The use of a pacifier may lower the risk of SIDS. Do not leave attached to infant's clothing while asleep.
- Room sharing in separate beds is recommended, but bed sharing with anybody else, including twins or other multiples, is not.
- Keep loose bedding and soft objects such as pillows, quilts, comforters, bumper pads, or sheepskin out of the crib.
- Evidence indicates that infants of women who receive regular prenatal care have a lower risk of SIDS.
- Avoid smoke exposure, alcohol, and illicit drug use during pregnancy and after birth because they are associated with an increased SIDS risk.
- Exclusive breastfeeding, if possible, for the first six months of life is recommended because it has been proven to help provide protection against SIDS, but any amount of breastfeeding has some protective effect.
- Once breastfeeding has been established, consider offering a pacifier to infants at sleep times. If it falls out of the mouth during sleep, it does not need to be reinserted because the protective effect from SIDS continues even after it has fallen out.
- Do not overdress the baby as overheating can be a risk factor.
- Make sure infants are up to date on their immunizations, which have a protective effect against SIDS.
- There is no reason to use devices such as wedges, positioners, special mattresses or sleep surfaces, or home cardiorespiratory monitors are advertised to prevent SIDS.
- Give the baby supervised tummy time every day while awake.

CAR SEAT SAFETY

Massachusetts State Law

- Infants and children must ride in a federally approved child passenger restraint until they are at least 5 years old and weigh more than 40 pounds.
- Children older than 5 and more than 40 pounds must ride in a booster seat until the child is 8 years old or is taller than 4 feet 9 inches (57 inches).
- Anyone over the age of 8 must be protected by a safety belt.

INFANTS AND TODDLERS—REAR-FACING

The AAP recommends that all infants should ride rear facing starting with their first ride home from the hospital. All infants and toddlers should ride in a **Rear-Facing Car Seat for as long as possible**. When children reach the highest weight or length allowed by the manufacturer of their rear-facing only seat, they should continue to ride rear-facing in a convertible seat or 3-in-1 seat.

1. **Rear-facing only**
    - Are used for infants up to 22 to 35 pounds, depending on the model.
    - Are small and have carrying handles (and sometimes come as part of a stroller system).
    - May come with a base that can be left in the car. The seat clicks into and out of the base, so you do not have to install the seat each time. You can buy more than one base for additional vehicles.
    - Are used only for travel (not for positioning outside the vehicle).

2. **Convertible seats (used rear facing)**
    - Can be used rear-facing, then "converted" to forward-facing for older children. This means the seat can be used longer by your child. They are bulkier than infant seats, however, and do not come with carrying handles or separate bases.
    - May have higher rear-facing weight (up to 40–45 pounds) and height limits than rear-facing only seats, which make them ideal for bigger babies.
    - Usually have 5-point harness that attaches at shoulders, hips, and between the legs. Older models may have an overhead shield, a padded tray-like shield that swings down over a child.
3. **3-in-1 seats (used rear-facing)**
    - Can be used rear-facing, forward-facing, or as a belt-positioning booster. This means the seat may be used longer by your child.
    - Are often bigger in size, so it is important to check that they fit in the vehicle while rear-facing.
    - Do not have the convenience of a carrying handle or a separate base; however, they may have higher rear-facing weight (up to 40–45 pounds) and height limits than rear-facing only seats, which make them ideal for bigger babies.

Children should be in a rear facing car seat at least until 2 years of age and for as long as possible.

FORWARD-FACING CAR SEATS

All children who have outgrown the rear-facing weight or height limit for their car seat, should use a **Forward-Facing Car Seat** with a harness for as long as possible, up to the highest weight or height allowed by their car seat's manufacturer. It is best for children to ride in a seat with a harness as long as possible, at least to 4 years of age. If your child outgrows his seat before reaching 4 years of age, consider using a seat with a harness approved for higher weights and heights.

5 types of car safety restraints that can be used forward-facing:

1. **Convertible seats**—Seats that "convert" from rear-facing to forward-facing seats. These include 3-in-1 seats.
2. **Forward-facing only**—Seats can be used forward-facing with a harness for children who weigh up to 40 to 80 pounds (depending on the model). Although manufacturers are not currently making any forward-facing only seats, many remain in use from previous years.
3. **Combination seat with harness**—can be used forward-facing with a harness for children who weigh up to 40 to 90 pounds (depending on the model) or without the harness as a booster (up to 80–120 pounds, depending on the model).

4. **Built-in seats**—Some vehicles come with built-in forward-facing seats. Weight and height limits vary. Read your vehicle owner's manual or contact the manufacturer for details about how to use these seats.
5. **Travel vests**—Vests can be worn by children between 20 and 168 pounds and can be an option to traditional forward-facing seats. Useful for when a vehicle has lap-only seat belts in the rear or for children whose weight has exceeded that allowed by car seats. These vests may require use of a top tether.

SCHOOL-AGED CHILDREN—BOOSTER SEATS

Booster seats are for older children who have outgrown their forward-facing car seats. All children whose weight or height is above the forward-facing limit for their car seat should use a Belt-Positioning Booster Seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age. The owner's manual that comes with your car seat will tell you the height and weight limits for the seat. As a general guideline, a child has outgrown his forward-facing seat when:

- Child reaches the top weight or height allowed for the seat with a harness. (These limits are listed on the seat and included in the instruction booklet.)
- Child's shoulders are above the top harness slots.
- Child's ears have reached the top of the seat.

Types of booster seats
Booster seats are designed to raise the child up so that the lap and shoulder seat belts fit properly over strong bones. High-back and backless booster seats are available. They do not come with harness straps but are used with the lap and shoulder seat belts in your vehicle, the same way an adult does. Booster seats should be used until your child can correctly fit in the adult lap and shoulder seat belts, typically when the child is around 4 feet 9 inches in height and 8 to 12 years old.

OLDER CHILDREN—SEAT BELTS

Seat belts are made for adults. Your child should stay in a booster seat until adult seat belts fit correctly (usually when the child reaches about 4 feet 9 inches in height and is between 8 and 12 years of age). When children are old enough and large enough to use the vehicle seat belt alone, they should always use Lap and Shoulder Seat Belts for optimal protection.

1. An adult seat belt fits correctly when:
   - The shoulder belt lies across the middle of the chest and shoulder, not the neck or throat.
   - The lap belt is low and snug across the upper thighs, not the belly.
   - Your child is tall enough to sit against the vehicle seat back with their knees bent without slouching and can stay in this position comfortably throughout the trip.
2. Other points to keep in mind when using seat belts include:
   - **Make sure your child does not tuck the shoulder belt under their arm or behind their back**. This leaves the upper body unprotected and adds extra slack into the seat belt system, putting your child at risk of severe injury in a crash or with sudden braking.
   - Never allow anyone to "share" seat belts. All passengers must have their own car seats or seat belts.

Q: What if my baby's feet touch the back of the vehicle seat?

A: Your child can bend his legs easily and will be comfortable in a rear-facing seat. Injuries to the legs are rare for children facing the rear.

Q: Can I adjust the straps when my baby is wearing thicker clothing, like in the winter?

A: Yes, but make sure the harnesses are still snug. Also remember to tighten the straps again after thicker clothes are no longer needed. Ideally, dress your baby in thinner layers instead of a bulky coat or snowsuit, and tuck a blanket around your baby over the buckled harness straps if needed.

Q: What do I need to know if my child will be driven by someone else, such as for childcare or school?

A: If someone is driving your child else, make sure:

- The car seat your child will use fits properly in the vehicle used for transport.
- The car seat is appropriate for the age and size of your child.
- The person in charge of transporting your child knows how to install and use the car seat correctly.

Q: What if my car only has lap belts in the back seat?

A: Lap belts work fine with rear-facing only, convertible, and forward-facing seats. If your car only has lap belts, use a forward-facing car seat that has a harness and higher weight limits. You also could:

- Check to see if shoulder belts can be installed in your vehicle.
- Use a travel vest (some can be used with lap belts).
- Consider buying a car with lap/shoulder belts in the back seat.

Q: Is there a difference between high-back and backless boosters?

A: Both types of boosters are designed to raise your child's height, so the seat belts fit properly. Both will reduce your child's risk of injury in a crash. High-back boosters are useful in vehicles without headrests or with low seat backs. Many seats that look like high-back boosters are combination seats. They come with harnesses that can be used for smaller children and then removed for older children. Backless boosters are usually less expensive and are easier to move from one vehicle to another. Backless boosters can be used safely in vehicles with head rests and high seat backs.

TYPES OF CAR SAFETY SEATS AT A GLANCE

Age Group	Type of Seat	General Guidelines
Infants/Toddlers	Rear-facing only seats and rear-facing convertible seats.	All infants and toddlers should ride in a **Rear-Facing Car Safety Seat** until they are least 2 years of age or until they reach the highest weight or height allowed by their car seat's manufacturer.
Toddlers/Preschoolers	Convertible seats and forward-facing seats with harnesses	Any child who has outgrown the rear-facing weight or height limit for his convertible car seat should use a **Forward-Facing Car Safety Seat** with a harness for as long as possible, up to the highest weight or height allowed by their car safety seat's manufacturer.
School-aged children	Booster seats	All children whose weight or height is above the forward-facing limit for their car safety seat, whose ears are above the back of the safety seat or whose shoulders are above the top strap slots should use a **Belt-Positioning Booster Seat** until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches (57 Inches) in height and are between 8 and 12 years of age.
Older children	Seat belts	When children are old enough and large enough for the vehicle seat belt to fit them correctly, they should always use **Lap and Shoulder Seat Belts** for optimal protection. All children younger than 13 years should be restrained in the **Rear Seats** of vehicles for optimal protection.
Massachusetts State Law		Infants and children must ride in a federally approved child passenger restraint until they are at least 5 years old and weigh more than 40 pounds. Children older than 5 and more than 40 pounds must ride in a booster seat until the child is 8 years old or is taller than 4 feet 9 inches (57 inches) Anyone over the age of 8 must be protected by a safety belt.

For more information visit http://www.healthychildren.org/english/safety-prevention/on-the-go/pages/car-safety-seats-information-for-families.aspx

FLYING WITH YOUR CHILD

How old does my baby need to be to fly?
There is no minimum age for your baby to fly. However, putting a couple hundred people into an enclosed space is a great way to spread colds and other germs. Therefore, as with any other exposure to large crowds, we recommend delaying flying until after your baby has had his or her first vaccines at 6wks of age.

What can I do for ear pain?
First, you should know that all children-or even most-experience ear pain when flying. If you have flown before, you know that take-off and landing can lead to pressure changes that cause ear discomfort. For older children and adults, chewing gum can help to relieve the pressure. For babies, sucking on a pacifier or feeding from the breast or a bottle can do the same thing. Pressure can start well before landing, so listen for the cabin announcement that the plane has begun its descent.

Lap child vs. car seat?
Confirm with your airline, but typically children under 2 years old can fly for free as a "lap child." However, a child in your lap- particularly a squirmy toddler- is not going to be safely secured should turbulence occur. Therefore, we recommend your child fly in his or her own seat. Be aware that when booking the flight that some airlines mandate that child seats be placed next to the window, and that most do not allow a child seat to be placed next to the aisle. Also, due to the number of oxygen masks, you cannot have two lap children in the same row.

Moving around
As you know, the average toddler does not sit still for very long unless he or she is asleep. Flying with younger infants is in some ways easier because they are not as mobile. If your child can move be prepared to allow them to move. On larger planes you may be able to get a seat in a bulkhead row where your child will have some space to play in front of you. Otherwise, expect to be taking at least a few laps up and down the aisle. You never know when turbulence can always occur so make sure to keep a hand on your child. Take advantage of the seatbelt off sign to move about the cabin.

Security
As you might guess going through security with small children can be particularly time-consuming. There are a few specific differences to the normal procedure you should be aware of:

- Breast milk, formula, and juice are allowed in volumes greater than the typical 3 oz limit, but need to be separated from other liquids, and need to be declared at the time of screening, they will be x-rayed and may also be swabbed for explosives. Freezer packs to keep the liquids cool are also allowed but must be fully frozen.
- Baby and infant foods are allowed with the same procedure as above.
- Children who cannot walk or more importantly hold still must be carried through the x-ray scanners rather than the body scanner.
- Strollers and car seats should go through the regular x-ray scanner with the rest of your luggage but can be hand screened if they do not fit.
- Children under 12 years old do not have to take off their shoes or light jackets for security.
- Check the TSA website for any updates to the above before travelling.

Practical tips

- Allow extra time for arrival at the airport and for any connecting flights.
- Bring extra clothes for you as well as your child.
- Having a pre-packed smaller bag with a changing pad, diapers, and wipes can make visits to the airplane bathroom easier.
- Even if you are checking a BOB or similar larger stroller, having a small collapsible umbrella stroller to gate check can make getting your child through the airport easier.

https://www.tsa.gov/travel/special-procedures/traveling-children

https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Flying-with-Baby.aspx

MILK GUIDELINES FOR CHILDREN OVER 1 YEAR OLD

When your baby is over one year old and he or she has a balanced diet of solid foods including cereals, vegetables, fruits, and meats, you may give the baby whole cow's milk.

Never give your baby more than 24 ounces of milk per day. More than this can provide too many calories and may decrease his or her appetite for other foods that they need. Other whole milk products such as cheese, yogurt etc. will provide additional calcium at this age.

Whole, Vitamin D fortified milk is recommended for children over 1 year old (until the 2nd birthday) because they still need a higher fat content to maintain normal weight gain and help their bodies absorb vitamins A and D, as well as help their brains develop. Reduced fat (2%) milk should only be used if directed by your pediatrician.

Do not give your baby low-fat (1%) or skim milk before the second birthday. Those types of milk have protein, sodium and mineral concentrations that are too high for children under age two and lack many essential fat-soluble vitamins due to the low-fat content. **Skim milk will not help your child avoid becoming overweight or cure diarrhea.**

Never boil milk. This increases the concentration and therefore makes it too strong for your baby's digestive system and kidneys.

JUICE GUIDELINES

There are many juices on the market which make it difficult to decide which one is best. Of more concern, however, is the fact that most of us, especially children, DRINK TOO MUCH JUICE!

Juice is the same as soda…when it comes down to sugar. Juice may have "all-natural" sugar, but your body does not know the difference. Sugar is sugar, whether it comes from an apple, an orange, a grape, sugar cane or high fructose corn syrup. Do not be fooled by "juice drinks." They may have the color of a juice, but may contain no juice at all, just corn syrup or high fructose corn syrup. Some "juices" have as little as 5% real fruit juice. It is not too hard to make better juice choices. **A better juice is fortified with vitamins and minerals. An example of this is fruit juice that contains 100% RDA of Vitamin C or has added Calcium.**

Many people drink juice because it is considered a serving of fruit. A 4-ounce glass of juice is a fruit serving, not 8 ounces, which is often the amount listed on the nutrition label.

You may wish to offer juice as a daily serving of Vitamin C (Ascorbic Acid). Vitamin C is thought to help ward off the common cold or flu. Vitamin C also helps your body absorb iron. If your child is considered "anemic" or low iron, Vitamin C will help the body use the iron in foods and supplements. It is a better idea to obtain Vitamin C from a food, such as an orange or a kiwi fruit, rather than juice. When you eat a fruit or vegetable that has Vitamin C you also get many other nutrients including fiber and other vitamins and minerals at fewer calories than juices.

Young babies and toddlers may have diarrhea if they drink too much juice. This is caused by a sugar called Sorbitol in the juice that has a laxative effect in the body. Remember too that drinking juice constantly, through a bottle or even a cup, may do harm to your child's teeth. The sugar (no matter what kind it is) that is left on the teeth will cause dental caries.

If your child is milk protein or lactose intolerant, you may offer calcium fortified orange juice to get the calcium that your child is missing. Do not offer calcium fortified juices instead of milk unless your child does not tolerate milk. See page 24 for more information about calcium requirements. Milk has many other nutrients besides calcium that are important for a growing body.

So, how much juice is enough? It depends on the age of your child, and his or her calorie requirements. Keep in mind this general guideline by age:

Infants (6 months)	0-2 ounces per day
Toddlers(2-3)	4-6 ounces per day
Pre-schoolers (4-5)	6-8 ounces per day
School Aged (6-12)	8 ounces per day
Teenagers (13-17)	8 ounces per day
Adults	8 ounces per day

Have you ever wondered how juice stacks up to other drinks? Here is a comparison of calories for a variety of drinks.

Beverage	Serving Size	Calories
Water	8 ounces	0
Diet soda	8 ounces	0
V8 100%	8 ounces	50
Skim milk	8 ounces	90
Coca-Cola	8 ounces	100
Pepsi	8 ounces	100
Root Beer	8 ounces	110
Orange juice	8 ounces	120
V8 Splash	8 ounces	120
"Cran" blends	8 ounces	140
Grape juice	8 ounces	155

If you are unsure of the amount your child should be having, make sure you ask your doctor, nurse, or dietitian.

A FEEDING GUIDE FOR GOOD NUTRITION:

A well-balanced diet with lots of variety is the key to good nutrition for your child. Basic food requirements generally can be met by eating a certain amount of food daily from each of the food groups. The basic food groups are breads and grains, vegetables, fruit, milk and dairy products, meat, and protein.

Recommended Daily Servings by Age

Breads and Grains
(Four to six or more servings)

	1 Year	2-3 Years	4-5 Years	6-9 Years	10-12 Years
Whole grain or enriched bread	½ slice	1 slice	1 ½ slices	1-2 slices	2 slices
Cooked cereals, rice, and pasta	4 tablespoons	5 tablespoons (1/3 cup)	½ cup	½ cup	¾ cup
Whole grain or fortified ready-to-eat cereals	½ cup	¾ cup	½ cup	½ cup	1 ½ cups

Vegetables and Fruits
(Three to five servings of vegetables; two to four servings of fruit)
This should include at least one serving each of a vitamin C and a vitamin A source.

	1 Year	2-3 Years	4-5 Years	6-9 Years	10-12 Years
Vitamin C sources: citrus fruits, berries, melons, peppers, tomatoes, broccoli, chilis, potatoes, cauliflower, cabbage	4 tablespoons (1/4 cup)	8 tablespoons (1/2 cup)	1/2 cup	1 cup	1 cup
Vitamin A sources: peaches, apricots, carrots, spinach, broccoli, squash, pumpkin, sweet potatoes, peas, brussels sprouts, beans (green, yellow, and lima), melons	2 tablespoons	3 tablespoons	¼ cup	¼ cup	1/3 cup
Other fruits and vegetables	2 tablespoons	3 tablespoons	½ cup	½ cup	½ cup

Milk and Dairy Products
(Three or four servings)

	1 Year	2-3 Years	4-5 Years	6-9 Years	10-12 Years
Milk	½ cup	1/2 -3/4 cup	½-3/4 cup	¾-1 cup	1 cup
Cottage cheese	¼ cup	½ cup	1 cup	1 cup	1 cup
Cheese (1 ounce=1 slice)	1 ounce	1 ounce	1 ounce	1 ½ ounces	1 ½ ounces
Custard, milk pudding	½ cup	¾ cup	¾ cup	1 cup	1 cup
Ice cream	½ cup	3/4cup	1 cup	1 ½ cups	1 ½ cups

Meat and Protein
(two or more servings)

	1 Year	2-3 Years	4-5 Years	6-9 Years	10-12 Years
Beef, poultry, fish, pork, and veal	2 tablespoons	3 tablespoons	2-3 ounces	3-4 ounces	4-5 ounces
Egg	1	1	1	1	1
Peanut butter	---	1 tablespoon	2 tablespoons	2-3 tablespoons	3 tablespoons
Cheese	1 ounce	1 ounce	1 ounce	2 ounces	2 ounces
Cooked legumes, dried beans, and peas	4 tablespoons	4 tablespoons	½ cup	¾ cup	1 cup

Fats/Oil
(Three servings or to meet caloric needs)

	1 Year	2-3 Years	4-5 Years	6-9 Years	10-12 Years
Butter, margarine, oil, mayonnaise, salad dressing	1 teaspoon	1 teaspoon	1 teaspoon	1 teaspoon	1 teaspoon

Sweets and "other" foods
(No amount recommended. When given, use in moderation.)

Sources include jam, jelly, olives, ketchup, pickles, candy, soft drinks, sweet desserts, etc.

SAMPLE MENU

Using these guidelines, a sample menu for a 2-year-old child might look something like this:

Breakfast
- 6 ounces milk, 1/3 cup oatmeal, 1 small banana, 1 teaspoon butter

Mid-Morning Snack
- 4 ounces orange juice, 2 graham crackers, ½ cup cottage cheese

Lunch
- 3 tablespoons baked white fish, 1 teaspoon tartar sauce, 3 tablespoons green beans, 1/3 cup brown rice, 3 tablespoons applesauce

Afternoon Snack
- 2 wheat crackers, 1 tablespoon peanut butter. 4 ounces milk

Dinner
- 6 ounces milk, 3 tablespoons baked skinless chicken breast, 1/3 cup pasta, 1 teaspoon butter, 3 tablespoons spinach, small, pitted apricot

Special Instructions: The actual menu plan for your child may vary depending on nutritional needs and eating preferences. Check with your dietitian for specific requirements to best meet the needs of your child.

DAILY CALCIUM REQUIREMENTS

AGE	Adequate Intake (mg)
Birth – 6 months	210
6 Months – 1 year	270
1 – 3 Years	500
4- 8 years	800
9-18 years	1300
19-50 years	1000
51+ years	1200

CALCIUM IN YOUR FOODS

Natural Diary Sources of Calcium (Approximate Calcium Amounts)

Milk (1 cup)	300 mg
Cheese (1 ounce)	175-275 mg
Cottage Cheese (1 cup)	140 mg
Yogurt (1 cup, low-fat/non-fruit)	415 mg
Yogurt (1 cup, low-fat/fruit)	315 mg
Ice Cream, Ice Milk, Pudding, Custard	150 mg

Natural Nondairy Sources of Calcium
(Approximate Calcium Amounts)

Calcium-enriched Orange Juice (1 cup)	300 mg
Tofu (with calcium sulfate, ½ cup)	324-434 mg
Sardines/Salmon (with bones, 3 ounces)	250 mg
Broccoli (cooked, 1 cup)	240 mg
Greens (turnip and beet) and Okra (1 cup)	150 mg
Cooked dried beans (1 cup)	50-150 mg

If using a calcium supplement, please keep in mind that your body can only absorb 500mg of calcium at one time and calcium should be taken with food.

ABRASIONS

Wash the abrasion with antibacterial soap and water and a washcloth. Pat the area dry. Apply an antibiotic ointment (bacitracin, Neosporin, etc.) and a Band-Aid. Observe for signs of infection such as increased redness, swelling, drainage or fever.

BURNS

There are many different causes of serious burns in children, including sunburn, hot-water scalds, and those due to fire, electrical contact, or chemicals. All of these can cause permanent injury and scarring of skin.

- **1st degree burns** are minor and heal quickly. Symptoms are redness, tenderness, and soreness (like most sunburn).
- **2nd degree burns** – serious injuries. First aid and medical treatment should be given as soon as possible. Symptoms are blistering (like severe sunburn), pain, and swelling.
- **3rd degree burns** (full-thickness burns) – severe injuries. Medical treatment is needed right away. Symptoms are white, brown, or charred tissue often surrounded by blistered areas. There may be little or no pain at first.
- **4th degree burns** – severe injuries that involve skin, muscle, and bone. These often occur with electrical burns and may be more severe than they appear. May cause serious complications and should be treated by a doctor right away.
- **ALL electrical burns should receive medical attention right away. Any burn on the hand, foot, face, genitals, or any burn over a joint that is worse than 1st degree should receive medical attention right away.**

Call our office if your child suffers anything more than a minor burn, or if redness and pain continue for more than a few hours.

Treatment

- As quickly as possible, soak the burn in cool water. Do not hesitate to run cool water over the burn long enough to cool the area and relieve the pain immediately after the injury. This also helps to prevent or reduce swelling.
- **Do not use ice on a burn**. It may delay healing. Also, do not rub a burn; it can increase blistering.
- Cool any smoldering clothing immediately by soaking with water, then remove any clothing from the burned area unless it is stuck firmly to the skin. In that case, cut away as much clothing as possible. Remove any jewelry or tight-fitting clothing from around the burned area before swelling begins. If possible, elevate the injured area.
- After the burn has cooled, cover it loosely with a dry bandage or clean cloth. Do not break any blisters. This could allow bacteria into the wound.
- **Never put grease (including butter or medical ointments) on the burn.** Grease holds in heat and may make the burn worse. It also makes the burn harder to examine by medical personnel later.
- Keep the person's body temperature normal. Cover unburned areas with a dry blanket.

CHICKENPOX (VARICELLA)

Chickenpox is a highly contagious disease caused by a virus called varicella zoster. Chicken pox used to be one of the most common diseases of childhood until the vaccine that protects against chickenpox became available in 1995.

Signs and Symptoms:

- Most children have relatively mild symptoms.
- Most children develop a mild fever for 1-2 days followed by:
- Eruption of small fluid-filled blisters that appear 10-21 days after exposure and infection with the virus.
- The blisters usually appear first on the torso and scalp, often surrounded by a reddened area. They may spread to other parts of the body, including the face, arms, and legs.
- Blisters may also occur in the scalp, mouth, throat, eye, and genital area.
- Crops of blisters can continue to erupt for 1 week, your child is contagious during this time.
- Therefore, children who have chickenpox should be kept at home until there are no new crops of erupting blisters and the current blisters are all crusted over (7-10 days on average).
- The contagious period begins 1 to 2 days prior to the first appearance of the rash and continues for another 5 to 7 days (or 24 hours after the last new blister develops).

General treatment for chickenpox includes:

- Trim fingernails and keep hands clean to minimize scratching and prevent infection. The rash itself could become infected with bacteria and leave small scars.
- Try a cool water bath with soap and water, or you can try oatmeal baths as sold in pharmacies.
- An oral antihistamine, such as Benadryl, can be useful to decrease itching. See page 51 for dosing guidelines. **Do not use antihistamine creams or lotions on the skin.**
- Tylenol as needed for fever or discomfort. Never give aspirin to a child with a fever. See page 50 for dosing guidelines.
- Calamine lotion can be used on skin for itching.

Keep your child away from other children and pregnant women who have never had chickenpox or the chickenpox vaccine. This is important for children with weakened immune systems.

CONJUNCTIVITIS

Conjunctivitis, commonly called pinkeye, is an inflammation of the mucous membrane on the inner side of the eyelids and covering the eyelashes. Conjunctivitis can be due to viruses, allergies, or a number of different bacteria.

If the conjunctivitis is bacterial, your child's pediatrician will prescribe an antibiotic to treat the infection. Therefore, it is important to know the signs and symptoms that tell if it is a bacteria or viral infection.

Viral Conjunctivitis

- White part of the eye may be red or pink.
- Inner eyelids are also red.
- Child may have watery discharge from eye.
- There will be NO yellow/green discharge or matting of eyelid.

Allergic Conjunctivitis

- White part of both eyes red.
- Itchy eyes.
- Watery discharge.

Bacterial Conjunctivitis – a common complication of a cold. It is not a bacterial infection unless these symptoms are present.

- Yellow discharge in the eye.
- Eyelids are stuck together with discharge, especially after naps. Dried eye discharge on the upper cheek.
- The white part of the eye MAY OR MAY NOT be red/pink.
- Eyelid may be mildly swollen due to irritation from infection.

If the infection is bacterial and an antibiotic is prescribed, it will be either eye drops or an ointment. Follow these instructions when treating:

- Clean discharge from the eye before instilling medication. If this is not done beforehand, the eye drops/ointment will not have a chance to work.
- Warm compresses can loosen the dried discharge.
- You can remove all the dried and liquid discharge from the eye with warm water and gauze or wet cotton balls (materials which can be easily thrown away to avoid spreading germs).
- Always wipe your eyes from the inner to outer corner.
- Continue giving the medication until your child wakes up for 2 mornings without any discharge in the eyes.
- ***If the child uses contact lenses, Take the contacts out and contact your optometrist/ophthalmologist.***
- Your child can return to school or day care after using medication for 24 hours if there is minimal discharge.
- Make sure your child uses the antibiotic for the prescribed time period, even if the symptoms disappear.

When to call your pediatrician

- If the infection lasts longer than 3 days (72 hours).
- A small amount of eyelid swelling can be normal. However, if your child has eyelid swelling that is worsening day by day, they need to be seen in the office
- A call to the office is also indicated if your child has:
    - Elevated temperature.
    - Tender, swollen red eyelids.
    - Complaints of eye pain.
    - Decreased vision.
    - Unusual light sensitivity.

Bacterial and viral infections are contagious, so make sure your child does not share towels, washcloths, or pillows with family members. Careful handwashing is the most important preventive measure.

Ear and throat infections frequently accompany eye infections. If your child develops symptoms of these illnesses, please call the office.

Any child under 3 years old with symptoms of conjunctivitis should be seen in the office due to the high incidence of concurrent ear infections.

COUGH AND COLDS

The common cold, with its associated symptoms, congestion, and cough, occurs with great frequency in children. It is caused by viruses that inflame the lining of the nose, throat, and larynx. It results in swelling of nasal passages and outpouring of fluid and mucus. Colds usually last about 7-10 days.

Most children get 8 to 10 colds before they are 2 years old. And if your child is in childcare, or if there are older school-age children in your house, they may have even more, since colds spread easily among children who are in close contact with one another. Children can get one cold right after another, so it may seem like your child is sick for a long time. The good news is most colds come and go without any big problems.

Unfortunately, there is no cure for the common cold since colds are caused by viruses. Antibiotics do not kill viruses so they will not make your child's cold better.

Your child may experience one or more of the following symptoms:

- Runny/stuffy nose, nasal discharge of varying color.
- Watery eyes.
- Crankiness/irritability.
- Fever.
- Decreased appetite.
- Cough.
- Sneezing.
- Sore throat.
- Mild fever (101–102 degrees Fahrenheit, 38.3–38.9 degrees Celsius), particularly in the evening.

Coughs usually last about a week but can even last for 10 days. If there is a fever, it should start at the start of the cold and then go away. Mucus in your child's nose may turn yellow or green after 3 or 4 days.

Treatment
A virus is not affected by antibiotics; therefore, treatment is aimed at making the child more comfortable.

Fever and/or irritability

- For a baby six months and under – give acetaminophen
- For a baby or child older than 6 months, give **either** acetaminophen or ibuprofen.
- However, never give ibuprofen to a child who is dehydrated or who has been vomiting repeatedly as it can upset the stomach.
- Both medications help with fever, but they are not the same. Be sure to get the right kind of medicine for your child's age and weight.
- Be sure to follow the recommended dosage for your child's age and the time interval for repeated doses.
- Call our office if you need advice on the dosing.
- Please see the dosing charts on page 50 for the proper dose for your child
- **NOTE: never give your child aspirin. It is dangerous for children younger than 18 years.**
- Do not give any other medicines without asking your pediatrician.

Runny/stuffy nose

- Clean your baby's nose with a suction bulb (also called an ear bulb). This works best for children under 6 months.
- Squeeze the bulb first and hold it in. Gently put the rubber tip into one nostril, and slowly release the bulb. This will suck the clogged mucus out of the nose.
- Thin the mucus – You can try 1-2 drops of saline nose drops (brands such as 'Ocean 'or 'Little noses') in each nostril prior to suctioning to help remove the mucus.
- Never use any other kind of nose drops unless your child's doctor prescribes them.

Environment

- Keep the house at a normal temperature but increase the humidity.
- Put a cool-mist humidifier in your child's room. A humidifier puts water into the air to help clear your child's stuffy nose.
- Be sure to clean the humidifier thoroughly each day to prevent bacterial or mold contamination. *Hot-water vaporizers are not recommended since they can cause serious scalds or burns.*

Increase fluid intake

- Encouraging extra fluids helps to combat increased mucus.
- Drinking plenty of liquids helps to avoid getting dehydrated.
- Clear liquids like juice mixed with water may work better than milk or formula if your child's nose is very stuffy.
- You may expect your child to have a decreased appetite during this illness. Forcing food may cause vomiting.

Cough

- A child's cough is a protective function and serves to clear bothersome, irritating mucus from the bronchi (passageways in the lungs).
- Cough preparations/syrups that promote loosening the cough or helping remove mucus are often not very effective. Encouraging fluids is a better approach.
- Check with our office regarding medication available and proper dosages. No cold or cough medication should be given to children under 6 years old.

When to call the Doctor
An older child with a cold usually does not need to see a doctor unless the condition becomes more serious. If your child is three months or younger, however, call the pediatrician at the first sign of illness. With a young baby, symptoms can be misleading, and colds can quickly develop into more serious ailments, such as bronchiolitis, croup, or pneumonia. For a child older than three months, call the pediatrician if:

- The nostrils are widening with each breath, the skin above or below the ribs sucks in with each breath (retractions), or your child is breathing rapidly or having any difficulty breathing.
- The lips or nails turn blue.

- Cold symptoms that get worse, instead of better, after a week.
- Nasal mucus persists for longer than ten to fourteen days.
- The cough just will not go away (it lasts more than two weeks).
- Any ear pain.
- Temperature is over 102 degrees Fahrenheit (38.9 degrees Celsius).
- Fever lasts more than 2 or 3 days.
- Child is excessively sleepy or cranky.

Prevention

- If your baby is under three months old, the best prevention against colds is to keep him/her away from people who have them. A virus that causes a mild illness in an older child or an adult can cause a more serious one in an infant.
- Make sure everyone washes their hands often; this will cut down on the spread of viruses.
- If your child is in childcare and has a cold, instruct her to cough and sneeze away from others, and to use a tissue to cough into and wipe their nose. Doing this may prevent them from spreading the cold to others.
- Using a tissue or a handkerchief is preferable to having your child cover their mouth with their hand when sneezing and coughing. If the virus lands on the child's hands, it can be transmitted to whatever the child touches—a sibling, a friend, or a toy.
- Do not share spoons, forks or drinking cups with anyone who has a cold, fever, or runny nose.
- Wash dishes in hot, soapy water.
- Do not smoke around your child. Keep your child away from cigarettes and other tobacco smoke.

Over the counter (OTC) cough and cold medicine

- **OTC cough and cold medicines should not be given to infants and children under six years old because of the risk of side effects.**
- Understand that using OTC cough and cold medicines does not cure the cold or cough. These medicines only treat your child's symptoms, such as runny nose, congestion, fever, and aches. They do not shorten the length of time your child is sick.
- In addition, keep in mind that coughing clears mucus from the lower part of the respiratory tract, and ordinarily there is no reason to suppress it.
- Talk to your pediatrician if you have any questions about using cough or cold medicines in children.

Tips for Parents

- Do not give children medications which are labeled only for adults.
- Cough and cold medications come in different strengths. If your child is over the age of 6 and you are unsure about the right product for your child, ask your pediatrician before giving any OTC medication.
- If your child takes any other medications (over the counter or prescriptions), your pediatrician needs to review the medications and approve their combined use.
- If your child is over the age of 6 and you choose to try an OTC medication, make sure to choose medicines with child-resistant safety caps. After each use, make sure to close the cap tightly and store the medicines out of sight and reach of children.
- Check the "active ingredients" section of the "Drug Facts" label of the medicines that you choose. This will help you understand what symptoms the active ingredients in the medicine are intended to treat. Cough and cold medicines often have more than one active ingredient, such as an antihistamine, a decongestant, a cough suppressant, an expectorant, or a pain reliever and fever reducer.
- **Be very careful** if you are giving more than one medicine to a child. Make sure the medicines do not have the same type of active ingredients.
- For example, do not give a child more than one medicine that has a decongestant. If you use two medicines that have the same or similar active ingredients, your child could be harmed or have serious side effects by getting too much (an overdose) of the ingredient.
- Follow the directions very carefully for how to use the medicine in the "Drug Facts" part of the label. The directions tell you how much medicine to give and how often you can give it. If you have a question about how to use the medicine, ask your pediatrician or pharmacist.
- DO NOT GIVE a child medicine more often or in greater amounts than is stated on the package instructions.
- **Overuse or misuse of these products can lead to serious and potentially life-threatening side effects, such as rapid heartbeat, drowsiness, breathing problems, and seizures**.

- Only use measuring devices that come with the medicine or those specially made for measuring drugs. Do not use household spoons to measure medicines for children because household spoons come in different sizes and are not meant for measuring medicines.
- IF YOU DO NOT UNDERSTAND the instructions on the product, or how to use the dosing device (Dropper, dosing cup or dosing spoon), DO NOT USE the medicine. Consult your pediatrician if you have questions or are confused.

CROUP

Croup is an illness usually caused by a virus that affects the larynx (voice box) and upper portions of the respiratory tract. The barky cough, hoarseness and noisy breathing are caused by swelling and inflammation in the larynx. Antibiotics, which treat bacteria, are not helpful because croup is caused by a virus or allergy.

Croup usually affects children between the ages of 3 months and 5 years. Often the child will have 1-2 days of runny nose, low grade fever and some hoarseness before the barky cough appears. Typically, the child awakens in the middle of the night with a cough, rapid noisy breathing, and fever.

The greatest danger with croup is that your child's airway will continue to swell, further narrowing their windpipe and making it difficult, at times almost impossible, to breathe. As your child tires from the effort of breathing, they may stop eating and drinking and may become too fatigued to cough.

Croup is a scary experience for both the parents and the child. Fortunately, most children can be easily managed at home. Give your child plenty of fluids and use a cool, moist vaporizer in their room at night. Try to appear CALM AND REASSURING.

If the vaporizer alone does not quiet the noisy/difficulty breathing (stridor) then you can try warm steam or cold air for relief. Make your bathroom into a steam-room by closing the door and turning the shower on hot. Sit with your child in the steamy room. Inhaling the warm, humidified air should ease her breathing within fifteen to twenty minutes. If there is no improvement with steam, try cold air. Weather permitting, bundle your child and bring outside for 15-20 minutes or stand in front of the open freezer.

Try to keep the child quiet; crying makes croup worse. You should call the office if these simple measures do not help any extreme agitation and restlessness, or if your child is having difficulty swallowing.

Your pediatrician may prescribe steroids to help decrease the swelling in the upper airway and throat and make it easier for the child to breathe. Cough syrups do not help.

Croup may last a week. Expect a few trips to the shower room or walks in the night air on these nights. Fever may last 3-5 days, and the cough may continue intermittently for up to 10 days. The child may often seem better during the day only to worsen at night.

Do *not* try to open your child's airway with your finger. Their breathing is being obstructed by swollen tissue beyond your reach, so you cannot clear it away. The child may throw up because of the coughing, but do not try to make the child vomit. Pay close attention to your child's breathing. ***Call 911 immediately*** if the child:

- Seems to be struggling to get a breath.
- Cannot speak because of a lack of breath.
- Gets excessively sleepy.
- Turns blue when coughing.

In the most serious cases, which are quite rare, your child will have a lot of difficulty breathing, and your pediatrician may admit the child to the hospital for a few days until the swelling in the airway gets better.

DIARRHEA

Diarrhea is defined as greater than 6 watery stools in a 24-hour period, regardless of color.

Home Care for Diarrhea in infants:

- Replace fluids with oral electrolyte solution such as Pedialyte. This will replace the salt and water that is lost with diarrhea. Contact the office about any child less than 6 months old.
- If formula fed return to formula by 24 hours at the latest.
- If you are breastfeeding, continue nursing at more frequent intervals.
- In children over 1 year old, give starchy foods that are well absorbed such as bananas, rice, applesauce, toast, mashed potatoes, noodles, and bread. Pedialyte is rarely needed unless the diarrhea is very watery and frequent.
- We DO NOT recommend over-the-counter diarrhea medications.
- Wash the buttocks after each BM to prevent a bad diaper rash. Use a protective ointment (Vaseline, butt paste, or triple paste, etc.) to protect skin.

Call our office right away for

- Signs of dehydration include:
    - No urine for over 6 hours.
    - Very dry mouth.
    - Crying produces no tears.
    - Sunken eyes.
- Any blood in stool.
- Abdominal pain that develops and lasts more than 4 hours.
- Diarrhea persisting for more than 1 week.
- High temperature or unusual drowsiness or irritability.

DENTAL EMERGENCIES

Toothache
Clean the area around the sore tooth thoroughly. Rinse the mouth vigorously with warm saltwater solution. Use dental floss to dislodge trapped food or debris. If the face is swollen, apply a cold compress, take acetaminophen, and see a dentist as soon as possible. DO NOT place aspirin on the gum or aching tooth.

Cut or bitten tongue, lip, or cheek
Apply ice to bruised areas. If there is bleeding, apply firm pressure with a clean gauze or cloth. If bleeding does not stop after 15 minutes, or cannot be controlled by simple pressure, call your pediatrician.

Loss of permanent tooth
Find the tooth. Handle the tooth by the crown, not the root. You may rinse the tooth, but do not handle or clean it unnecessarily. Try to reinsert into socket. Have the child hold the tooth into place by biting a clean gauze or cloth. If you cannot reinsert the tooth, transport it in a clean cup containing milk or water. See a dentist immediately, time is a critical factor in saving the tooth.

Broken Tooth
Rinse off injured area with warm water. Place cold compress over the area of injury. Locate and save any broken tooth fragments. Immediate dental attention is necessary.

Possible broken jaw
Make sure that the patient does not move jaw. Refrain from talking, eating/drinking etc. Call the office immediately.

Bleeding after baby tooth falls out
Fold and place a clean gauze or cloth over the bleeding area. Have the child bite on the gauze with pressure for 15 minutes. This may be repeated once. If bleeding continues, see a dentist.

Cold/canker sores
Over-the-counter preparations usually relieve symptoms of cold or canker sores. Utilize warm saltwater rinses. However, it is important to have a dental evaluation if these sores persist.

Broken braces and wires
If a wire is stuck in the cheek or gums, do not remove it. Call the dentist or orthodontist. Remove a loose or broken appliance that can be removed easily and contact the dentist or orthodontist.

EAR INFECTION (OTITIS MEDIA)

Middle-ear infections (which doctors call *otitis media)* are more common at younger ages than during middle childhood.

When an ear is infected, the eustachian tube becomes blocked. Fluid then builds up in the middle ear and bacteria begin to grow there. When this occurs, there is increased pressure on the eardrum, and it can no longer vibrate properly. Hearing is therefore reduced temporarily, and the pressure on the eardrum can also cause pain.

If an infection is present, your physician may prescribe antibiotics to destroy the bacteria and diminish the buildup of fluids.

Cause
Viruses or bacteria can cause ear infections. The only way to be sure if your child has an ear infection is to examine the eardrum.

Symptoms

- **Pain** is the most common symptom of an ear infection. Older children can tell you that their ears hurt. Younger children may only seem irritable and cry.
- **Loss of appetite** because of ear pain.
- **Trouble sleeping** because of the ear pain.
- **Fever** ranging from 100°F (normal) to 104°F.
- **Ear drainage** – may be yellow or white fluid, possibly blood-tinged, draining from your child's ear.
    - May have a foul odor
    - Will look different from normal earwax
    - Ear drainage is not an emergency, but your child does need to be seen in the office.
    - If pus or cloudy fluid is draining from the ear canal, the eardrum may have ruptured from an ear infection.
    - Wipe the pus away as it appears.
    - Avoid plugging with cotton because retained pus causes irritation or infection of the ear canal

- **Trouble hearing-** During and after an ear infection, your child may have trouble hearing for several weeks.
  Fluid behind the eardrum gets in the way of sound transmission.
  Usually temporary and will clear up after the fluid from the middle ear drains away.

Reassurance

- If your child's earache begins after our office is closed, diagnosis and treatment can safely wait until morning.
- Ear pain can be controlled with pain medicine.
- Give **acetaminophen** or **ibuprofen** as needed for pain relief or fever above 102°F. See page 50 for dosing guidelines.
- **Local cold or heat:** Apply a cold pack or a cold, wet washcloth to the outer ear for 20 minutes to reduce pain while the pain medicine takes effect. Some children prefer local heat for 20 minutes. Try using a heating pad or a warm towel over the ear.
- An earache or ear infection is not contagious. There is no need to miss any school or childcare.

SWIMMER'S EAR (OUTER EAR INFECTION)

Swimmer's ear (Otitis Externa) is an inflammation of the external ear canal which can happen when water gets into the ear (usually during swimming or bathing) and does not properly drain. When that happens, the canal can become irritated and infected.

Symptoms

- Severe ear pain- worsens when the ear is touched or tugged.
- Itching in the ear canal.
- Greenish-yellowish discharge.
- Temporary hearing loss in the affected ear as canal becomes swollen or filled with pus.
- Redness around the ear canal opening.

If your child is complaining of any of the above symptoms, they should be seen in the office. The provider will do a thorough medical history and physical examination, including an ear exam using an otoscope.
If there is evidence of an outer ear infection, the provider will begin treatment with ear drops.

- Drops contain antibiotics to kill certain bacteria, as well as medication for inflammation.
- The average course of treatment runs approximately one week. Occasionally, the infection is severe enough to warrant the additional use of an oral (by mouth) antibiotic.
- Please keep in mind that ear pain from external otitis may get worse for a day or two before the drops take effect.
- Keep the ears dry and continue taking the medication as directed.
- Try to keep the ear canal as dry as possible during the healing process. Dry the ears with a towel immediately after swimming or bathing. No underwater swimming while being treated.
- Give **acetaminophen** or **ibuprofen** as needed for pain relief or fever above 102°F
- **Local cold or heat:** Apply a cold pack or a cold, wet washcloth to the outer ear for 20 minutes to reduce pain while the pain medicine takes effect. Some children prefer local heat for 20 minutes. Try using a heating pad or a warm towel over the ear.
- To help prevent future episodes, place drops in the ears after swimming—either a 70 percent alcohol solution or a mixture of one-half alcohol, one-half white vinegar.

FEVER AND YOUR CHILD

A fever is usually a sign that the body is fighting an illness or infection. Fevers are generally harmless. In fact, they can be considered a good sign that your child's immune system is working, and the body is trying to heal itself. While it is important to look for the cause of a fever, the main purpose for treating it is to help your child feel better. Read on to find out more about how to tell if your child has a fever and how to manage a fever.

What is a fever?
A fever is a body temperature that is higher than normal. Normal body temperature varies with age, general health, activity level, and time of day; even how much clothing a person wears can affect body temperature. A temperature above 100.4°F (38°C) is a fever.

Signs and symptoms of a fever
If your child has a fever, he/she may feel warm, appear flushed, or sweat more than usual. He/she may also be more thirsty than usual. Some children feel fine when they have a fever. However, most will have symptoms of the illness that is causing the fever. Your child may have an earache, a sore throat, a rash, or a stomachache. These signs can provide important clues as to the cause of the fever.

When to call the doctor
Call your child's doctor right away if your child has a fever and

- Looks very ill, is unusually drowsy, or is very fussy.
- Has been in a very hot place, such as an overheated car.
- Has other symptoms such as a stiff neck, severe headache, severe sore throat, severe ear pain, an unexplained rash, or repeated vomiting or diarrhea.
- Has immune system problems such as sickle cell disease, cancer, or is taking steroids.
- Has had a seizure.
- Is younger than 3 months and has a rectal temperature of 100.4°F (38°C) or higher.
- If your child is unimmunized or follows an alternative vaccine schedule.
- If your child has a history of febrile urinary tract infections or urinary reflux.
- If your child has travelled outside of the United Sates recently.
- If your child is less than 6 weeks old and has not received the 6 weeks vaccines, bring the baby directly to the ER.

Taking your child's temperature
While you often can tell if your child is warmer than usual by feeling his forehead, only a thermometer can tell how high the temperature is.
A digital thermometer can be used to take a rectal (in the bottom), oral (in the mouth), tympanic (in the ear), temporal (forehead) or axillary (under the arm) temperature. Your child's doctor can recommend how to use it depending on your child's age. Taking a rectal or oral temperature is more accurate than taking an axillary temperature. Tympanic (ear) thermometers should not be used on children under 6 months of age.

Mercury thermometers should not be used. The American Academy of Pediatrics encourages parents to remove mercury thermometers from their homes to prevent accidental exposure to this toxin.

If your child is younger than 6 months, taking a rectal temperature gives the best reading.

H**ow to take a rectal temperature with a digital thermometer**: Up until the age of 6 months, you should check your baby's temperature rectally.

- Clean the end of the thermometer with rubbing alcohol or soap and water. Rinse it with cool water. Do not rinse it with hot water.
- Put a small amount of lubricant such as Vaseline or petroleum jelly on the end.
- Place your child, belly down, across your lap or on a firm surface. Hold the child by placing your palm against their lower back, just above their bottom. Or place your child face up and bend the child's legs to their chest. Rest your free hand against the back of the thighs.
- With the other hand, turn the thermometer on and insert it ½ inch to 1 inch into the anal opening. Do not insert it too far. Hold the thermometer in place loosely with 2 fingers, keeping your hand cupped around your child's bottom. Keep it there for about 1 minute, until you hear the "beep". Then remove and check the digital reading.
- Be sure to label the rectal thermometer so it is not accidentally used in the mouth.

How to take an oral temperature:

- Clean the thermometer with lukewarm soapy water or rubbing alcohol. Rinse with cool water.
- Turn the thermometer on and place the tip under the tongue toward the back of their mouth. Hold in place for about 1 minute, until you hear the "beep". Check the digital reading.
- For a correct reading, wait at least 15 minutes after your child has had a hot or cold drink before putting the thermometer in his mouth. Although not as accurate, if your child is older than 3 months, you can take the underarm temperature to see if the child has a fever.

How to take an axillary temperature:

- Place the tip of a digital thermometer in your child's armpit.
- Hold his arm tightly against his chest for about 1 minute, until you hear the "beep". Check the digital reading.

How to reduce a fever with medicine

Tylenol (acetaminophen) and Motrin/Advil (ibuprofen) are safe and effective medicines for reducing fevers. They do not need a prescription and are available at grocery stores and drugstores. However, keep the following in mind:

- Motrin/Advil (ibuprofen) should only be used for children older than 6 months. It should not be given to children who are vomiting constantly or are dehydrated.
- Do not use aspirin to treat your child's fever. Aspirin has been linked with side effects such as an upset stomach, intestinal bleeding and, most seriously, Reye syndrome.
- Before giving your child any medicine, read the label to make sure that you are giving the right dose for the age and weight. Also, if your child is taking other medicines, check the ingredients. If they include acetaminophen or ibuprofen, let your child's doctor know. To be safe, talk with your child's doctor if your child is younger than 2 years.
- If your child is vomiting and unable to take medication orally, you may use a rectal Tylenol (acetaminophen) suppository; the dose will be the same as the oral Tylenol (acetaminophen).

How to reduce a fever with sponging

Your child's doctor may recommend that you try sponging your child to reduce a fever if necessary.

- Use lukewarm water, not cold water. Cold water can cause shivering and increase the temperature. Never add rubbing alcohol to the water. Rubbing alcohol can be absorbed into the skin or inhaled, causing serious problems such as a coma.
- Usually, 5 to 10 minutes in the tub is enough time for a child's fever to start dropping. If your child becomes upset during the sponging, simply let them play in the water. If they are still bothered by the bath, it is better to take him/her out even if they have not been in long enough to reduce the fever. **Also remove the child from the bath if they continue to shiver because shivering can raise the temperature.**

Be sure to call your child's doctor if your child still "acts sick" once his fever is brought down, or if you feel that your child is very sick. Also call if the fever persists for

- More than 24 hours in a child younger than 2 years.
- More than 3 days is a child 2 years of age or older.

What if my child has a febrile seizure?

In some young children, fever can trigger seizures. While this can be frightening, seizures are usually harmless. During a seizure, your child may look strange for a few minutes; shake, then stiffen, twitch, and roll his eyes. If this happens:

- Place the child on the floor or bed, away from any hard or sharp objects.
- Turn his/her head to the side so that any saliva or vomit can drain from his mouth.
- Do not put anything into their mouth, not even a finger.
- If the seizure lasts under 5 minutes, call your child's doctor.
- If the seizure lasts more than 5 minutes, call 911.
- Your child's doctor will want to check your child, especially if it is their first seizure. It is important to look for the cause of the febrile seizure.

For Tylenol and Motrin dosing charts, please see page 50.

HEAD TRAUMA

Brain rest is important after a head injury; it is important that you contact our office for instructions.

Types of Head Injuries

SCALP INJURY: Most head injuries only damage the scalp (a cut, scrape, bruise or swelling). It is common for children to fall and hit their head at some point while growing up. This is especially common when a child is learning to walk.

- Big lumps (bruises) can occur with minor injuries because there is a large blood supply to the scalp. For the same reason, small cuts on the head may bleed a lot.
- Bruises on the forehead sometimes cause black eyes 1 to 3 days later because the blood spreads downward by gravity.

SKULL FRACTURE: Only 1% to 2% of children with head injuries will get a skull fracture. Usually there are no other symptoms except for a headache at the site where the head was hit. Most skull fractures occur without any injury to the brain, and they heal easily.

CONCUSSION: A concussion is an injury to the brain that changes how the brain normally works. It is usually caused by a sudden blow or jolt to the head. Many children bump or hit their heads without causing a concussion.

The most common signs of a concussion are:

- A brief period of confusion or
- Memory loss following the injury.

Other signs of a concussion can include

- Headache.
- Vomiting.
- Dizziness.
- Acting dazed.
- Being knocked out. A person does **NOT** need to be knocked out (lose consciousness) to have had a concussion.

Following a concussion, some children have ongoing symptoms for several weeks such as

- Mild headaches.
- Dizziness.
- Thinking difficulties.
- School problems.
- Emotional changes.

BRAIN INJURIES are uncommon but are recognized by the presence of the following symptoms:

- Difficult to awaken or keep awake.
- Confused thinking and talking.
- Slurred speech
- Weakness of arms or legs
- Unsteady walking

Call 911 Now (your child may need an ambulance) If:

- A seizure (convulsion) occurred.
- Knocked unconscious.
- Not moving neck normally (caution: protect the neck from any movement).
- Difficult to awaken.
- Confused thinking, slurred speech, unsteady walking OR weakness of arms/legs present now.
- Major bleeding that cannot be stopped.
- Watery fluid dripping from the nose or ear while child not crying.
- Large dent in skull.
- Injury caused by high speed (e.g., auto accident) or blow from hard object (e.g., golf club), or fall from large height.

Call Our Office Now (night or day) if:

- You think your child has a serious injury.
- Age under 1 year old.
- Neck pain.
- Had confused thinking, slurred speech, unsteady walking, OR weakness of arms/legs BUT fine now.
- Blurred vision persists for more than 5 minutes.
- Skin is split open or gaping and may need stitches.
- Bleeding will not stop after 10 minutes of direct pressure.
- Large swelling (larger than 1 inch or 2.5 cm).
- Fall from a dangerous height (over 3 feet [1m] if less than 2 years, and over 5 feet [1.5m] if older than 2 years).
- Vomited 2 or more times within 3 days of injury.
- Severe headache or crying.
- Cannot remember what happened.
- You think your child needs to be seen urgently.

Call Our Office Within 24 Hours (between 8 am and 4 pm) if:

- You think your child needs to be seen, but not urgently.
- Headache persists over 3 days.

Call Our Office During Weekday Office Hours if:

- You have other questions or concerns.
- No tetanus shot in over 5 years for DIRTY cuts (over 10 years for CLEAN cuts).

Brain Rest is important following a head injury. It is important that you call our office for instructions.

HEAD LICE

Head lice are a common childhood problem and can occur at any age, although they most frequently affect the school-aged child. Diagnosis is frequently made by the school nurse who finds the nits in a child's hair.
The most common symptom of head lice is itching. Most itching happens behind the ears or the back of the neck. Itching caused by head lice can last for weeks, even after the lice are gone.

- **Please note** that head lice are "equal opportunity" pests. Their presence does not imply poor hygiene or bad parenting. Head lice do not require 'urgent' treatment and can best be dealt with at home.
- Head lice do not put your child at risk for any serious health problems. If your child has head lice, work quickly to treat your child to prevent the head lice from spreading.

Checking for head lice

- Seat your child in a brightly lit room.
- Part the hair and look at your child's scalp – Look for crawling lice and for nits.
- **Live lice** avoid light and move quickly, may be hard to find.
- **Nits** look like small white or yellow-brown specks and will be firmly attached to the hair near the scalp. The easiest place to find them is at the hair line at the back of the neck or behind the ears.
- Use a fine-toothed comb to help comb out the lice or nits. Comb through your child's hair in small sections. After each comb-through, wipe the comb on a wet paper towel. Examine the scalp, comb, and paper towel carefully.

Chemical treatments

- Many of the shampoos and cream rinses that can be found at your local pharmacy contain 1% permethrin, a chemical that works very well to treat head lice. **Always follow the directions on the package very carefully. Do Not use on children younger than 2 months.**
- Head lice treatments may not always kill all the eggs. A second treatment is often necessary 7-10 days after the first treatment. Contact our office if your child still has head lice after the first treatment.

You can continue to comb out the nits after the hair has been treated. This may help prevent misdiagnosis with an active case of head lice. Please call our office if you have any questions.

"Comb-out" method

- Some parents choose to use the "comb-out" method. Damp hair can be combed out with a fine-toothed comb every day for 2 weeks. This approach often fails.

Home remedies like petroleum jelly, mayonnaise, tub margarine, herbal oils, or olive oil have not been scientifically proven to work. **Never coat your child's hair with dangerous products like gasoline, kerosene, or products that are made for use on animals.**

Other tips

- You do not need to throw away any items belonging to your child, but you may want to wash your child's clothes, towels, hats, and bed linens in hot water and dry.
- Do not spray pesticides in your home because they can expose your family to dangerous chemicals.
- If your child has head lice, all household members and close contacts should also be checked and treated if necessary.

INSECT BITES AND STINGS

Your child's reaction to a bite or sting will depend on the sensitivity to the insect's venom. While most children have only mild reactions, those who are allergic to certain insect venoms can have severe symptoms that require emergency treatment.

In general, bites are usually not a serious problem, but in some cases, stings may be. While it is true that most stings (from yellow jackets, wasps, and fire ants, etc.) may cause pain and localized swelling, severe anaphylactic reactions are possible.

Treatment

Although insect bites can be irritating, they usually begin to disappear by the next day and do not require a doctor's treatment.

- To relieve the itchiness that accompanies bites by mosquitoes, flies, fleas, and bedbugs, apply a cool compress and/or calamine lotion freely on any part of your child's body except the areas around her eyes and genitals.
- If a wasp or bee stings a child, soak a cloth in cold water and press over the area of the sting to reduce pain and swelling.
- Call your pediatrician before using any other treatment, including creams or lotions containing antihistamines or home remedies. If the itching is severe, please call the office.
- It is very important to remove a bee stinger quickly and completely.
- The quick removal of a bee stinger will prevent a large amount of venom from being pumped into the skin
- If the stinger is visible, remove it by gently scraping it off horizontally with a credit card or your fingernail.
- **Avoid squeezing the stinger with a pair of tweezers; doing this may release more venom into the skin.**
- The skin may be more swollen on the second or third day after a bee sting or mosquito bite.
- Contrary to popular belief, giving antihistamines continuously throughout the insect season does not appear to prevent reactions to bites.

Keep your child's fingernails short and clean to minimize the risk of infection from scratching.

- If infection does occur, the bite will become redder, larger, and more swollen.
- In some cases, you may notice red streaks or yellowish fluid near the bite, or your child may get a fever. Call our office right away; it may need to be treated with antibiotics.

Call 911 immediately if your child has any of these other symptoms after being bitten or stung:

- Sudden difficulty in breathing.
- Weakness, collapse, or unconsciousness.
- Hives or itching all over the body.
- Extreme swelling near the eyes, lips, or penis that makes it difficult for the child to see, eat, or urinate.

Prevention

It is impossible to prevent all insect bites, but you can minimize the number your child receives by following these guidelines.

- Avoid areas where insects nest or congregate, such as garbage cans, stagnant pools of water, uncovered foods and sweets, and orchards and gardens with flowers in bloom.
- When you know your child will be exposed to insects, dress her in long pants and a lightweight long-sleeved shirt.
- Avoid dressing your child in clothing with bright colors or flowery prints, because they seem to attract insects.
- Do not use scented soaps, perfumes, or hair sprays on your child, because they are inviting to insects.

Insect repellents are available without a prescription but should be used sparingly on infants and young children. The most common insecticides include DEET, a chemical not recommended for use on children under 2 months of age**.**

- The concentrations of DEET range from less than 10 % to over 30 %, so read the label of any product you purchase.
- Effectiveness peaks at 30 %, however, which is also the maximum concentration currently recommended for children.
- Avoid products that include DEET plus a sunscreen, because sunscreen needs to be applied frequently while DEET should not. Applying DEET more frequently may be associated with toxicity.
- Be sure to wash off the DEET with soap and water at the end of the day.
- Picaridin is a DEET alternative and is pleasant-smelling, without the oil residue associated with DEET. It is available in concentrations of 5 to 10 %.
- The American Academy of Pediatrics recommends that repellents used in children over six months of age have 30 percent DEET or 5 to 10 percent picaridin repellent, **applied once** before going outdoors.
- These are effective in preventing bites by mosquitoes, ticks, fleas, chiggers, and biting flies, but have no effect on stinging insects like bees, hornets, and wasps.

Insect/Environment	Characteristics of Bite or Sting	Special Notes
Mosquitoes Water (pools, lakes, birdbaths)	Stinging sensation followed by small, red, itchy mound with tiny puncture mark at center.	Mosquitoes are attracted by bright colors and sweat.
Flies Food, garbage, animal waste	Painful, itchy bumps; may turn into small blisters.	Bites often disappear in a day but may last longer.
Fleas Cracks in floor, rugs, pet fur	Multiple small bumps clustered together; often where clothes fit tightly (waist, buttocks).	Fleas are most likely to be a problem in homes with pets.
Bedbugs Cracks of walls, floors, crevices of furniture, bedding	Itchy red bumps occasionally topped by a blister; usually 2–3 in a row.	Bedbugs are most likely to bite at night and are less active in cold weather.
Fire ants Mounds in pastures, meadows, lawns, and parks in southern states	Immediate pain and burning; swelling up to 1⁄2 inch (1.2 cm); cloudy fluid in area of bite.	Fire ants usually attack intruders.
Bees and wasps Flowers, shrubs, picnic areas, beaches	Immediate pain and rapid swelling.	A few children have severe reactions, such as difficulty breathing and hives/swelling all over the body.
Ticks Wooded areas	May not be noticeable; hidden on hair or on skin.	Do not remove ticks with matches, lighted cigarettes, or nail polish remover; grasp the tick firmly with tweezers near the head; gently pull the tick straight out.

TICK BITES AND LYME DISEASE

There are many different types of ticks in the United States, some of which are capable of transmitting infections. The risk of developing these infections depends upon geographic location, season of the year, type of tick, and, for Lyme disease, **how long the tick was attached to the skin.**

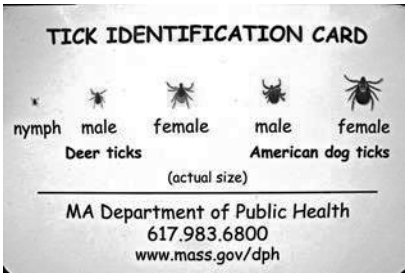
- While many people are concerned after a tick bite, **the risk of acquiring a tick-borne infection is quite low, even if the tick has attached, fed, and is carrying an infectious agent.**
- Only ticks that are attached can transmit Lyme disease. After arriving on the skin, the tick that spreads Lyme disease usually takes 24 hours before feeding begins.
- **Ticks transmit infection only after they have attached and have finished feeding or are near the end of their meal**. A tick that has not attached (and therefore has not yet become engorged from its blood meal) has not passed any infection.
- Since the deer tick that transmits Lyme disease must feed for >36 hours before transmission of the bacteria, the risk of acquiring Lyme disease from an observed tick bite is only 1.2 – 1.4 percent, even in areas where the disease is common.

If a person is bitten by a deer tick (the type of tick that carries Lyme disease), a healthcare provider will advise that you:

- Observe and treat if signs or symptoms of infection develop. **There is no benefit of blood testing for Lyme disease at the time of the tick bite.**
- Even people who become infected will not have a positive blood test until two to six weeks after the infection develops (post-tick bite).
- Lyme disease can be effectively treated with appropriate antibiotics.
- Antibiotic prophylaxis may be indicated if the deer tick was attached for more than 48 hours.

HOW TO REMOVE A TICK

- Carefully remove the tick and make note of its appearance. Only deer ticks cause Lyme disease.



The proper way to remove a tick is to use a set of fine tweezers and grip the tick as close to the skin as possible.

DO NOT USE a smoldering match or cigarette, nail polish, petroleum jelly (e.g., Vaseline), liquid soap, or kerosene because they may irritate the tick and cause it to behave like a syringe, injecting their bodily fluids into the wound.

The proper technique for tick removal includes the following:

- Use fine tweezers to grasp the tick as close to the skin surface as possible.
- Pull backwards gently but firmly, using an even, steady pressure. Do not jerk or twist.
- Do not squeeze, crush, or puncture the body of the tick, since its bodily fluids may contain infection-causing organisms.
- After removing the tick, wash the skin and hands thoroughly with soap and water.
- If any mouth parts of the tick remain in the skin, these should be left alone; they will be expelled on their own. Attempts to remove these parts may result in significant skin trauma.

AFTER THE TICK IS REMOVED

Tick characteristics – It is helpful if the person can provide information about the size of the tick, whether it was attached to the skin, if it was engorged (that is, full of blood), and how long it was attached.

- The size and color of the tick helps to determine what kind of tick it was.
- Ticks that are brown and the size of a poppy seed or pencil point are deer ticks. These can transmit the bacterium that causes Lyme disease and several other tick-borne infections.
- Ticks that are brown with a white collar and about the size of a pencil eraser are more likely to be dog ticks.

Signs of Lyme disease

- The characteristic rash of Lyme disease is called erythema migrans (EM).
- Usually salmon colored, can be intense red.
- Lesions expand over a few days or weeks, can be over 8 inches in diameter.
- Approximately 80% of people with Lyme develop EM, and 10-20% will have multiple lesions.
- As the rash expands, it can become clear (skin-colored) in the center. The center of the rash can then appear a lighter color than its edges or the rash can develop into a series of concentric rings giving it a "bull's eye" appearance.
- A rash the size of a dime or quarter is not Lyme disease. Some parts of tick saliva can cause a short-lived (24 to 48 hours) rash that should not be confused with EM.
- Flu-like symptoms – may develop fever, chills, sore throat, or headache.
- Call our office if your child has a known tick bite and develops any sick symptoms, rash, or for any other questions or concerns.

POISON IVY

Poison Ivy is a very itchy, blistering rash caused by contact with the oil of a poison ivy plant. Oil is found in the leaves, stems, berries, and roots of the plant. Contrary to popular belief, **poison ivy is not contagious from person to person.** You must come into direct contact with the oil. The oil can be spread from the plant to clothing, towels etc., and may be carried by pets. Following exposure to poison ivy, bathe the child as soon as possible in cool water without soap. All clothing and towels used following contact with the plant oil should be run through the wash.

Poison ivy is not contagious to others. There is no need for your child to miss any school or childcare.

Symptoms

- Localized redness, swelling, and weeping blisters.
- Located on exposed body surfaces (such as the hands) or areas touched by the hands (e.g., the face or genitals). May be carried by pets.
- Extreme itchiness.
- Onset 1 or 2 days after the patient was in a forest or field.
- Rash is shaped like streaks or lines.

Treatment

- Treatment is aimed at relieving symptoms of intense itching and occasional swelling.
- **We do not recommend the use of topical antihistamine preparations such as Benadryl cream or Caladryl as these may be dangerous, but Calamine lotion is fine.**
- Oral Benadryl (liquid or capsules) may be taken to control itching. See page 51 for dosing guidelines.
- Over-the-counter Hydrocortisone cream three times per day may provide further relief.
- **IF THE RASH INVOLVES THE FACE NEAR THE EYES OR THE GENITAL AREA, PLEASE CONTACT US FOR FURTHER ADVICE.**

Call our office for

- Difficulty breathing or severe coughing following exposure to burning weeds.
- If the rash looks infected (e.g., soft yellow scabs, pus or spreading redness).
- Swelling is severe (e.g., the eyes are swollen shut).
- Severe poison ivy reaction in the past.
- Rash involves more than one fourth of the body.
- Face, eyes, lips, or genitals are involved.
- Severe itching (e.g., cannot sleep).
- Big blisters or oozing sores
- Taking oral steroids for over 24 hours and rash becoming worse.
- Rash lasts longer than 3 weeks.

SORE THROATS

Throat infections (pharyngitis, tonsillitis) are painful and make all of us miserable at one time or another. Two types of organisms (germs) cause throat infections: viruses and bacteria. The most important bacteria infecting the throat is streptococcus (strep throat).

Most throat infections are caused by viruses and not strep. Unfortunately, the symptoms and severity of viral and strep throats are so similar that we cannot accurately tell one from another by examination alone, a throat culture is necessary. **Symptoms such as a red throat, white spots on the back of the throat, fever and swollen glands are common to both viral and bacterial throat infections and do not necessarily indicate strep throat.**

It is important to treat strep throats with antibiotics because treatment prevents the rare late complication of rheumatic fever with rheumatic heart diseases.

Strep throat is NOT an emergency and treatment need not be started immediately to prevent rheumatic fever complications. It is best to wait to test for strep until a child has had symptoms for 24 hours, testing too early can lead to a false-negative result.

A child with strep is considered contagious to others until he has been on antibiotics for at least 12 hours. After that period, your child may return to their usual activities if they feel well. We recommend that other children in the family come to our office within 48 hours for strep testing if they are showing signs of strep illness.

Viral infections are NOT helped by antibiotics. They resolve on their own in 3-5 days. Therefore, **we do not prescribe antibiotics without first doing a strep test.**

Many summer-time viruses cause sore throats which are accompanied by sores inside the mouth, on the inside of the cheeks and on the tongue. These sores may be red spots and/or look like canker sores. They are often associated with increased drooling or discomfort. Cool liquids may provide some relief. Antibiotics are not indicated.

Remember:

- A rapid strep test is a simple/quick way to identify those children who need antibiotics.
- Children with strep are contagious for 12 hours after the start of therapy.
- After 12 hours on antibiotics, you should discard your child's toothbrush and get a new one.
- A rapid strep test should be done on any other family members who complain of a sore throat within 48 hours.
- General treatment measures include:
  - Frequent liquids
  - Gargles
  - Sprays
  - Lozenges
  - Tylenol
  - Time
- If parents are experiencing a sore throat, we urge them to seek medical attention from their physician.
- It is NEVER appropriate for a parent to begin antibiotics on a child for possible strep without a rapid strep/throat culture.

SUNBURN

Everyone is at risk for sunburn, although those with darker skin coloring tend to be less sensitive to the sun. Most sun damage occurs in childhood therefore children need to be protected from the sun's burning rays. **The best policy regarding sunburn is prevention.**

Like other burns, sunburn will leave the skin red, warm, and painful. In severe cases, sunburn can cause blistering, fever, chills, headache, and a general feeling of illness.

Children can be harmed by the sun without being burned. Sun exposure effects build over the years, even moderate exposure can lead to wrinkling, toughening, freckling and even skin cancer later in life.

Treatment

The signs of sunburn usually appear 6 to 12 hours after exposure, with the greatest discomfort during the first 24 hours.

- If sunburn is just red, warm, and painful, you can treat it at home.
- Apply cool compresses to burned areas or bathe in cool water.
- You also can give acetaminophen to help relieve the pain.
- You may use aloe-vera gel.

Call our office if the sunburn causes blisters, fever, chills, headache, or a general feeling of illness.

- Severe sunburn must be treated like any other serious burn. If it is very extensive, hospitalization is sometimes required.
- Blisters can become infected and may require antibiotics.
- Extensive or severe sunburn can lead to dehydration and, in some cases, fainting (heatstroke). Such cases need to be examined by your pediatrician or at the nearest E.R.

Prevention

It is important to remember that it is the invisible ultraviolet rays that are harmful; therefore, it is incorrect to assume that the sun is dangerous only when it is shining brightly.

- Children may be exposed to more ultraviolet rays on foggy, hazy days because they feel cooler and stay outside longer.
- Big hats or umbrellas are not absolute protection because UV rays reflect off sand, water, snow, and many other surfaces.
- Try to keep your child out of the sun when the peak ultraviolet rays occur (between 10 A.M. and 4 P.M.).

In addition, follow these guidelines:

- Always use sunscreen to block the damaging ultraviolet rays. Choose a sunscreen made for children with a SPF of at least 30 and should provide **UVA and UVB** protection. Apply the protection half an hour before going out. Keep in mind that *no* sunscreens are truly waterproof, thus they need to be reapplied every 1.5 to 2 hours, particularly if your child spends a lot of time in the water. Follow instructions on the bottle.
- Dress your child in lightweight cotton clothing with long sleeves and long pants.
- Use a beach umbrella or similar object to keep child in the shade as much as possible.
- Have the child wear a hat with a wide brim.
- **Babies under six months of age should be kept out of direct sunlight**. If adequate clothing and shade are not available, sunscreen may be used on small areas of the body, such as the face and the backs of the hands.

TEETHING

Teething is one of the most frequent parental concerns in the first two years of their child's life. Every baby teethes. Some babies experience minimal discomfort and some babies become uncomfortable. However, there is no easy "cure" for teething.

In the third month of life or so, babies begin to drool and gnaw at things. Grandparents may call this "teething." Developmentally, however, this drooling is to be expected. Babies do not get the first of their 20 primary teeth until between the ages of 5-7 months. Some babies' teeth earlier and other babies do not begin to cut their first teeth until one year of age. There is great variability in the timing of teething. If your child does not show any teeth until later than this age period, do not worry. The timing may be determined by heredity, and it does not mean that anything is wrong. **It is important to note that development of teeth is not related to other developmental milestones**.

The two front teeth (central incisors), either upper or lower, usually appear first, followed by the opposite front teeth. The first molars come in next, followed by the canines or eyeteeth. The pattern of tooth eruption may vary.

Teething may *occasionally* cause mild irritability, crying, a low-grade temperature (but not over 101 degrees Fahrenheit or 38.3 degrees Celsius), excessive drooling, and a desire to chew on something hard. More often, the gums around the new teeth will swell and be tender. To ease your baby's discomfort, try gently rubbing or massaging the gums with one of your fingers. Teething rings are helpful, too, but they should be made of firm rubber. (The teethers that you freeze tend to get too hard and can cause more harm than good.). Teething biscuits should be used with caution, if at all, as the baby may bite off a piece. Parents can also utilize Tylenol for pain relief.

Pain relievers and medications that you rub on the gums are not necessary or useful since they wash out of the baby's mouth within minutes. Some medication you rub on your child's gums can even be harmful if too much is used, and the child swallows an excessive amount. If your child seems particularly miserable or has a fever higher than 101 degrees Fahrenheit (38.3 degrees Celsius), it is probably not teething, and you should consult your pediatrician.

VOMITING

Vomiting and diarrhea occur in childhood for many reasons. Most commonly, they occur as symptoms of gastroenteritis (stomach bug). The illness frequently lasts 5-7 days and is often accompanied by stomachache and fever. The most serious consequence of gastroenteritis is dehydration, which occurs when body fluid losses are greater than fluid intake. ***If an infant has a wet mouth, cries tears and is urinating well, they are not dehydrated***.

Home care for Vomiting

- Allow the stomach to rest completely for one hour after vomiting.
- Start with a small amount (1 tablespoon) of electrolyte solution (Pedialyte) every 10 minutes. (Unflavored Pedialyte may be flavored with small amounts of fluid that the child may prefer. Pedialyte frozen pops also work well.)
- After 1-2 hours without vomiting, slowly increase the amount of clear fluids.
- After 8 hours without vomiting, you can start bland, starchy foods (saltine crackers, white bread, rice, soup, mashed potatoes) and progress to a regular diet.

Call our office right away if:

- Signs of dehydration include
    - No urine in over 6 hours.
    - Very dry mouth.
    - Crying produces no tears.
    - Sunken eyes.
- Any blood in vomit.
- Abdominal pain that develops and lasts more than 4 hours.
- Vomiting continues for more than 24 hours in a child under age 2, or for more than 48 hours if the child is over age 2.
- High temperature, stiff neck or unusual drowsiness or irritability.

PARENTING RESOURCES

PARENTING THE YOUNG CHILD

- **TOUCH POINTS** By: T. Berry Brazelton – Explores cognitive and emotional development of children from birth to 5 years old.

- **BABYHOOD** By: Penelope Leach

- **123 MAGIC** By: Dr. Phelan - Parenting 2-12-year old's. Particularly good, very direct parenting has worked for anyone who has invested in the concept.

- **HOW TO TALK SO YOUR KIDS WILL LISTEN AND LISTEN SO YOUR KIDS WILL TALK** By: A. Saber

- **SIBLINGS WITHOUT RIVALRY** By: A. Saber

- **THE NEGOTIATION GENERATION**
  By: Lynne Reeves – This wonderful book gives good sound advice regarding limit setting, boundaries, and communication.

- **THE HAPPIEST BABY ON THE BLOCK DVD**

- **USEFUL WEBSITES:**
  - www.parenting.com
  - www.familyeducation.com
  - www.onetoughjob.org
  - www.healthychildren.org

- **GOOGLE**
  - Medline Plus to bring up many areas of interest.

PARENTING ADOLESCENTS / TEENS

- **SURVIVING ADOLESCENCE** By: L. Dumont – This book deals with what is "normal" and when to seek help as your child begins their road to adulthood.

- **GET OUT OF MY LIFE, BUT FIRST CAN YOU DRIVE ME AND CHERYL TO THE MALL?**
  By: A. Wolf – Typical teenage actions and reactions to school, peers, and parents.

- **REVIVING OPHELIA** By: Mary Pipher – Understanding your daughter and social pressures.

- **RAISING A SON** By: D. Elium – Understanding your son and how society affects your parenting.

- **REAL BOYS** By: W. Pollack, Ph.D. – An in-depth look at raising a son in today's world.

- **TEENAGE SURVIVAL BOOK** By: Sol Gordon

- **WHEN GOOD KIDS DO BAD THINGS** By: K. Levine

DEATH / GRIEF / LOSS

- **THE TEN BEST THINGS ABOUT BARNEY** By: J. Viorst – Written to be read to a young child.
- **ABOUT DYING** By: Sarah Stein – For ages 3-6 years old.
- **WHEN NOTHING MATTERS ANYMORE** By: Bev Cobain (Kurt Cobain's cousin) – Explores suicide and how survivors cope with the loss.
- **HELPING THE GRIEVING CHILD** By: Helen Fitzgerald – A book for actual or impending loss regarding funerals, calling hours and appropriate responses to questions.
- **THE PHOENIX PHENOMENON** By: Joanne Jozefowski – A local author who talks about picking up the pieces after a loss, whether sudden or expected.
- **USEFUL WEBSITE:**
  - www.dougycenter.com

EXTREME BEHAVIORAL CONCERNS

- **THE EXPLOSIVE CHILD** By: Ross Greene – A psychiatrist out of Mass General describes the extensive work done on the child who rages and is challenging.
- **FREEING YOUR CHILD FROM OCD** By: T. Chansky – An informative book to read if you have concerns for OCD, and a step-by-step treatment program.
- **RAISING YOUR SPIRITED CHILD** By: Mary Sheedy Kurcinka – A guide for parents whose child is more intense, sensitive, perceptive, persistent, or energetic.

SLEEP ISSUES

- **SOLVE YOUR CHILD'S SLEEPING PROBLEMS** By: Dr. Ferber – Another doctor/author from Mass General Hospital. A terrific book to read when you are trying to get your child into a good sleeping routine. Dr. Ferber also has a practice in Boston for sleep issues.
- **THE BABY WHISPERER** By: Tracy Hogg
- **HEALTHY SLEEP HABITS, HAPPY CHILD** By: Marc Weissbluth

SUBSTANCE ABUSE

- **RAISING A DRUG FREE KID IN A DRUG FILLED WORLD** By: W. Perkins
- **USEFUL WEBSITE:** www.theantidrug.com

DIVORCE

- **THE GOOD DIVORCE** By: C. Ahrons – Great book for families trying to figure out the logistics of divorce. Jewish Family Services in Worcester MA has a parent education program called "**Children Cope with Divorce."** Visit the website for more information at www.jfsworcester.org

COLLEGE

- **ALMOST GROWN** By: P. Pasick – Launching your child from high school to college.

SEX

- **IT'S PERFECTLY NORMAL** By: R. Harris

GAY / LESBIAN CHILDREN

- **LOVING SOMEONE GAY** By: D. Clark
- **PARENTS MATTER** By: A. Muller
- **GOOGLE**
  - GLAAD or PFLAG

EATING DISORDERS

- **SURVIVING AN EATING DISORDER** By: M. Siegel
- **HUNGER PAINS** By: Mary Pipher

DATING VIOLENCE

- Call **1-800-322-2303** for information or brochures regarding prevention and intervention.
- **DATING VIOLENCE** By: Levy Barrie – A helpful book about young women in danger.

SOCIAL DEVELOPMENT

- **THE PRICE OF PRIVILEGE** By: M. Levine, Ph.D. – Parental pressure and material advantage are creating a generation of disconnected and unhappy kids.
- **BEST FRIENDS, WORST ENEMIES** By: M. Thompson, Ph.D. – Understanding the social life of children.
- **QUEEN BEES AND WANNA BEES: HELPING YOUR DAUGHTER SURVIVE CLIQUES, GOSSIP, BOYFRIENDS, AND OTHER REALITIES OF ADOLESCENCE** By: Rosalind Wiseman – The book that the movie "Mean Girls" was based on. Looks at the structure of today's teenage girls.

HUMOR

- **I WAS A REALLY GOOD MOM BEFORE I HAD KIDS: REINVENTING MODERN MOTHERHOOD** By: Trisha Ashworth and Amy Nobile

NUTRITION

- **HOW TO GET YOUR KID TO EAT: BUT NOT TOO MUCH** By: Ellen Satter
- **CHILD OF MINE: FEEDING WITH LOVE AND GOOD SENSE** By: Ellen Satter
- **THE FAMILY NUTRITION BOOK** By: William Sears, M.D. and Martha Sears, R.N.
- **TRIM KIDS** By: Melinda Sothern, T. Kristian von Almen, and Heidi Schumach
- **EATING WELL ON CAMPUS** By: Ann Litt
- **FUEL FOR YOUNG ATHLETES** By. Ann Litt
- **THE HEALTHY COLLEGE COOKBOOK** By: Alexander Nimetz, Jason Stanley, Emiline Starr
- **THE DIET FOR TEENAGERS ONLY** By: Carrie Wiatt and Barbara Schroeder
- **Useful websites:**
    - www.healthyamericans.org
    - www.fruitsandveggiesmatter.gov/index.html
    - www.cdc.gov
    - www.nutrition.gov
    - www.choosemyplate.gov
    - www.nhlbi.nih.gov

DIRECTIONS TO CHILD HEALTH ASSOCIATES, P.C., AUBURN

TO AUBURN LOCATION – 105 MILLBURY STREET

- Take 290 West to Exit #13 (Auburn Street, Auburn). Take a **left** at the first set of lights at the end of the exit ramp. Go **straight** through the next two sets of lights. After the second set of lights, take a **left** to go over the railroad tracks and then an immediate **right** to go under the overpass. You are now on MILLBURY STREET. We are on the **left side**, near the end of Millbury Street where it intersects Route 20.

- Take 290 East and get off at Exit #13 (Swanson Road). Take a **right** at the end of the ramp. Go **straight** through the next two sets of lights. At the third set of lights, take a **right**. Take a **left** to go over the railroad tracks and then an immediate **right** to go under the overpass. You are now on MILLBURY STREET. We are on the **left side**, near the end of Millbury Street where it intersects Route 20.

- Take Route 20 West into Auburn. Take a **right** after the Shell Gas Station on your **right**. You will now be on MILLBURY STREET. We are next door to the Shell Gas Station, on your **right**.

- Take Route 20 East into Auburn. Take a **left** at the intersection where Farmer's Daughter is on your **right** and the Shell Gas Station is on your **left**. Take that **left** – you are now on MILLBURY STREET. We are on your **right**, next door to the Shell Gas Station.

FROM AUBURN LOCATION TO ST. VINCENT HOSPITAL – 20 Worcester Center Blvd., Worcester

- Take a **right** out of our parking lot onto MILLBURY STREET.
- Stay to the **left** and go under the overpass. At your first light take a **right** onto AUBURN STREET.
- You will pass the Auburn Mall on your **left**, keep going **straight** through the next 2 sets of lights.
- Take the I-290 East ramp towards WORCESTER/MARLBOROUGH - Merge onto I-290 East.
- Take Exit #20 (Martin Luther King Jr Boulevard) towards DOWNTOWN WORCESTER.
- Turn **left** onto EAST CENTRAL STREET.
- Turn **left** onto SUMMER STREET– **Worcester Medical Center** is on your right.

FROM AUBURN LOCATION TO UMASS MEDICAL CENTER - MEMORIAL CAMPUS – 119 Belmont Street, Worcester

- Take a **right** out of our parking lot onto MILLBURY STREET.
- Stay to the **left** and go under the overpass. At your first light take a **right** onto AUBURN STREET.
- Go past the Auburn Mall on your **left** and go **straight** through the next 2 sets of lights.
- Take the I-290 East ramp towards WORCESTER/MARLBOROUGH - Merge onto I-290 East.
- Take Exit #21 (ROUTE 9) towards WARE/FRAMINGHAM.
- Turn **right** onto BELMONT STREET/MA 9. – **UMASS Memorial Hospital** is on your **left.**

FROM AUBURN LOCATION TO UMASS MEDICAL CENTER – UNIVERSITY CAMPUS – 55 Lake Avenue North, Worcester.

- Take a **right** out of our parking lot onto MILLBURY STREET.
- Stay to the **left** and go under the overpass. At your first light, take a **right** onto AUBURN STREET.
- Go past the Auburn Mall on your **left** and go **straight** through the next 2 sets of lights.
- Take the I-290 East ramp towards WORCESTER/MARLBOROUGH - Merge onto I-290 East.
- Take Exit# 19 (Shrewsbury Street).
- Merge onto SHREWSBURY ST.
- Turn **slight right** onto BELMONT ST./MA-9 E and get in **left hand** lane.
- At the light, turn **left** onto PLANTATION STREET
- Turn **right** onto SOUTH STREET and **Umass Medical Center University Campus** parking lot.

FROM AUBURN LOCATION TO CHILD HEALTH ASSOCIATES, P.C. – 604 Main St., Shrewsbury

- Take a **right** out of our parking lot onto MILLBURY STREET.
- Stay to the **left** and go under the overpass. At your first light, take a **right** onto AUBURN STREE.
- Go past the Auburn Mall on your **left** and go **straight** through the next 2 sets of lights.
- Take the I-290 east ramp towards WORCESTER/MARLBOROUGH - Merge onto I-290 East.
- Take Exit #26A (140 South – Shrewsbury).
- Stay on 140 SOUTH until you reach your first set of lights.
- Go **straight** through the lights, and **Child Health Associates, P.C., Shrewsbury Locations** is immediately on your **left.**

DIRECTIONS TO CHILD HEALTH ASSOCIATES, P.C., SHREWSBURY

TO SHREWSBURY LOCATION – 604 Main Street

- Take 290 East to Exit #26A (140 South – Shrewsbury).
  - Stay on 140 SOUTH until you get to the first set of lights.
  - Go **straight** through the first set of lights – we are immediately on your **left**, just after the set of lights.
- Take 290 West to Exit 26A (140 South – Shrewsbury).
  - Stay on 140 SOUTH until you get to the first set of lights.
  - Go **straight** through the first set of lights – we are immediately on your **left**, just after the set of lights.
- From Route 9, get onto Route 140 NORTH.
  - Go **straight t**hrough the first set of lights.
  - Continue Route 140 NORTH – our office will be on your **right** – across the street from the Lilliput Day Care Center.

FROM SHREWSBURY LOCATION TO ST VINCENT'S HOSPITAL – 20 Worcester Center Blvd., Worcester

- Take a **right** out of our parking lot onto GRAFTON STREET.
- Go **straight** through the intersection and bear **left** onto 140 NORTH / I-290.
- Take I-290 WEST towards AUBURN.
- Take Exit #21 (Route 9) WARE/FRAMINGHAM.
- Keep **right** at the fork in the ramp and merge onto LINCOLN STREET/MA-70S.
- LINCOLN STREET/MA-70S becomes LINCOLN SQUARE/SUMMER STREET.
- **Worcester Medical Center** is on your right.

FROM SHREWSBURY LOCATION TO UMASS MEDICAL CENTER – MEMORIAL CAMPUS – 119 Belmont St., Worcester.

- Take a **right** out of our parking lot onto GRAFTON STREET.
- At the MAIN STREET intersection take a **left**.
- At your next light bear **left** onto MAPLE AVE. and follow to the end where you will take a slight **right** onto BOSTON TURNPIKE – BOSTON TURPIKE becomes ROUTE 9 WEST, which then becomes BELMONT STREET.
- Follow BELMONT STREET for 1.9 miles, **Umass Medical Center – Memorial Campus** is on your left.

FROM SHREWSBURY LOCATION TO UMASS MEDICAL CENTER – UNIVERSITY CAMPUS – 55 Lake Avenue North, Worcester

- Take a **right** out of our parking lot onto GRAFTON STREET.
- At the MAIN STREET intersection take a **left**.
- At your next light bear **left** onto MAPLE AVE. and follow to the end where you will take a slight **right** onto BOSTON TURNPIKE – BOSTON TURPIKE becomes ROUTE 9 WEST.
- Continue **straight** over the LAKE QUINSIGAMOND BRIDGE.
- At the end of the bridge, get in the **right-hand** lane.
- Turn **right** onto NORTH LAKE AVENUE.
- Take your first **left** onto NORTH ROAD – **Umass Medical Center – University Campus** is on your left

FROM SHREWSBURY LOCATION TO CHILD HEALTH ASSOCIATES, P.C. – 105 Millbury St., Auburn

- Take a **right** out of our parking lot onto GRAFTON STREET.
- Go **straight** through intersection and bear **left** onto 140 N / I-290.
- Take I-290 WEST towards AUBURN to Exit #13 (Auburn Street).
- Take a **left** at the first set of lights at the end of the exit ramp.
- Go **straight** through the next two sets of lights. After the second set of lights, take a **left** to go over the railroad tracks and then an immediate **right** to go under the overpass. You are now on MILLBURY STREET.
- **Child Health Associates, P.C., Auburn location** is on the **left**, before the Shell Gas Station.

CHILDREN'S AND JUNIOR STRENGTH TYLENOL
Acetaminophen

CHILD'S WEIGHT CHILD'S AGE		**CHILDREN'S/INFANT'S TYLENOL® SUSPENSION LIQUID** 160 mg/5 mL	**CHILDREN'S TYLENOL® MELTAWAYS** 80 mg each	**JUNIOR TYLENOL® MELTAWAYS** 160 mg each
6-11 lbs. / 0–3 months		1.25 mL	**CONSULT YOUR CHILD'S DOCTOR**	
12-17 lbs. / 4-11 months		2.5 mL		
18-23 lbs. / 12-23 months		3.75 mL		
24-35 lbs. / 2-3 years		1 TSP or 5 mL	2 TABLETS	NOT RECOMMENDED
36-47 lbs. / 4-5 years		1 ½ TSP or 7.5 mL	3 TABLETS	NOT RECOMMENDED
48-59 lbs. / 6-8 years		2 TSP or 10 mL	4 TABLETS	2 TABLETS
60-71 lbs. / 9-10 years		2 ½ TSP or 12.5 mL	5 TABLETS	2 ½ TABLETS
72-95 lbs. / 11 years		3 TSP or 15 mL	6 TABLETS	3 TABLETS
96+ lbs. / 12 years		NOT RECOMMENDED	NOT RECOMMENDED	4 TABLETS

NOTE: If possible, use weight to dose; otherwise use age. To arrive at the correct dose, weigh your child before giving TYLENOL ®. All dosages may be repeated every 4 hours, but not for more than 5 times daily.

CHILDREN'S MOTRIN/ADVIL
Ibuprofen

Take every 6-8 hours as needed		Infant's Drops 50 mg/1.25 mL	Children's Liquid 100 mg/tsp.	Chewable Tablets 50 mg	Junior Chewable 100 mg/tab	Junior Caplets 100 mg	Advil 200 mg
Dose by Weight	**Age**	**Dropper**	**Teaspoon**	**Tablet**	**Tablet**	**Caplet**	**Caplet**
Under 6 months		Do Not Use					
12-17 lbs.	6-11 months	(1.25 mL)					
18-23 lbs.	12-23 months	(1.875 mL)					
24-35 lbs.	2-3 years	(2.5 mL)	1 tsp.	2 tablets	1 tablet		
36-47 lbs.	4-5 years		1 ½ tsp.	3 tablets	1 ½ tablets	1 ½ caplets	
48-59 lbs.	6-8 years		2 tsp.	4 tablets	2 tablets	2 caplets	1 caplet
60-71 lbs.	9-10 years		2 ½ tsp.	5 tablets	2 ½ tablets	2 ½ caplets	1 caplet
72-95 lbs.	11 years		3 tsp.	6 tablets	3 tablets	3 caplets	1 caplet
96-119 lbs.	12 years				4 tablets	4 caplets	2 caplets
121-150 lbs.							3 caplets

NOTE: If possible, use weight to dose; otherwise use age. To arrive at the correct dose, weigh your child before giving MOTRIN/ADVIL®. Recommended daily dose is 30 mg/kg. A healthcare professional should be consulted for a dose for children under the age of two years.

Instructions for Alternating Tylenol and Motrin

The following guide only applies to children over the age of 6 months.

Children under the age of 6 months should not be given Motrin.

When to Alternate Tylenol and Motrin:

- When a patient with a history of febrile seizures spikes a fever.
- Patients over the age of 6 months with a fever that is greater than 103 that is not responding to a single medication.

How to Alternate Tylenol and Motrin:

- Alternate the medications every 4 hours.
- For example: Give Tylenol and then 4 hours later give Motrin, 4 hours later give Tylenol then 4 hours later give Motrin.
- Make a chart to track the times you are giving each medication.

Helpful Notes:

- Tylenol is the same as Acetaminophen
- Motrin is the same as Ibuprofen and Advil

Benadryl / Diphenhydramine

	Allergy Liquid Medication 12.5 mg / 5 ml	**Dye-Free Allergy Liquid 12.5 mg / 5 ml**	**Allergy Chewable 12.5 mg / tab**	**Allergy Ultra-Tab 25 mg / tab**
Dosing Frequency	**DO NOT EXCEED DOSES**			
	Every 4 – 6 hours	Every 4 – 6 hours	Every 4 – 6 hours	Every 4 – 6 hours
Below 9 months or 18 lbs.	**Check with Physician**			
18 – 22 lbs.	¾ tsp. every 6 hours	¾ tsp. every 6 hours		
23 – 30 lbs.	1 tsp. every 6 hours	1 tsp. every 6 hours	1 tab every 6 hours	
31 – 44 lbs.	1½ tsp. every 6 hours	1½ tsp. every 6 hours	1½ tab every 6 hours	
45 – 60 lbs.	2 tsp. every 6 hours	2 tsp. every 6 hours	2 tabs every 6 hours	1 tab every 6 hours
61 – 85 lbs.	2½ tsp. every 6 hours	2½ tsp. every 6 hours	2½ tabs every 6 hours	1 tab every 6 hours
86 – 100 lbs.	3 tsp. every 6 hours	3 tsp. every 6 hours	3 tabs every 6 hours	1 tab every 6 hours
101 lbs. – Adult	4 tsp. every 6 hours	4 tsp. every 6 hours	4 tabs every 6 hours	2 tabs every 6 hours

*Dosage should be individualized according to the needs and responses of the patient.

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