Very Important Information
Please Read!

2 Week Visit

Date: _____

Length: _____ **in.**	**Weight:** _____ **lbs.** _____ **oz.**	**Head Circumference:** _____**in.**	**BP:**_____
Percentile: _____%	**Percentile:** _____%	**Percentile:** _____%	**BMI:**_____ **Percentile:** _____%

Check-up and Immunization Schedule

Age	Check-up*	Immunizations/Tests Due
2 wk.	within 3 days	Hep B #1 (if not given in hospital)
2 mo.	within 1 week	Pentacel #1; Hep B #2; Prevnar #1; Rotavirus #1 Maternal Depression Screen
4 mo.	within 2 weeks	Pentacel #2; Prevnar #2; Rotavirus #2 Maternal Depression Screen
6 mo.	within 3 weeks	Pentacel #3; Prevnar #3; Rotavirus #3 OAE Hearing & Spot Vision Screens Maternal Depression Screen
9 mo.	within 3 weeks	Hep B #3 Developmental Screen
12 mo.	MUST be after 1 yr. b'day	MMR #1; Varicella #1 OAE Hearing & Spot Vision Screens; CBC Lead Screen (if indicated)
15 mo.	within 3 weeks	Prevnar #4; Hep A #1
18 mo.	within 3 weeks	Pentacel #4 Developmental Screen
2 yr.	within 2 mo.	Hep A #2 Developmental Screen Anemia Screen w/CBC (if indicated)
30 mo.	within 2 mo.	Developmental Screen Anemia Screen w/CBC (if indicated)
3 yr.	within 2 mo.	OAE Hearing & Spot Vision Screens Anemia Screen w/CBC (if indicated)
4 yr.	MUST be after 4 yr. b'day	MMR #2; Varicella #2; Quadracel Hearing & Spot Vision Screens Anemia Screen w/CBC (if indicated)

***Time specified can either be before or after date of the specified age.**

Vaccines

Hep A/B=Hepatitis A/B
DTaP=Diptheria, Tetanus, Pertussis
IPV=Inactivated Polio Vaccine
MMR=Measles, Mumps, Rubella
Pentacel=DTap, Polio, Hib
Prevnar=Pneumococcal Vaccine
Td=Tetanus, Diptheria
Tdap=Tetanus, Diptheria, Pertussis
Quadracel=DTap, Polio

Age	Check-up*	Immunizations/Tests Due
5 yr.	yearly	Hearing & Titmus Vision Screens Anemia Screen w/CBC (if indicated)
6 yr.	yearly	Hearing & Titmus Vision Screens Anemia Screen w/CBC (if indicated)
7 yr.	yearly	----------
8 yr.	yearly	Hearing & Vision Screens Anemia Screen w/CBC (if indicated)
9 yr.	yearly	----------
10 yr.	yearly	Hearing & Vision Screens Anemia Screen w/CBC (if indicated) Lipid Panel
11 yr.	yearly	Tdap; Meningococcal #1; HPV Series Anemia Screen w/CBC (if indicated)
12-21 yrs.	yearly	Anemia Screen w/CBC (if indicated) 12, 15, 18 yrs. Hearing & Vision Screens 13 & up Adolescent Confidential Questionnaire 16 yr. Meningococcal #2 17 yr. Lipid Panel 21 yr. Td HPV Series if not already completed
ALL		Flu vaccine yearly for all patients 6 mos. & older

Tests

CBC=Complete Blood Count
OAE=Otoacoustic Emissions

Notes:

_____

_____

_____

YOUR BABY'S NEXT CHECK-UP IS DUE AT 2 MONTHS OF AGE.
PLEASE SCHEDULE THIS APPOINTMENT TODAY.

UPDATE: 2-2-2023

TABLE OF CONTENTS

Northside Pediatrics' Vaccine Policy

Northside Pediatrics firmly believes in the effectiveness of vaccines to prevent serious illnesses and save lives. We only follow the CDC schedule for vaccine administration which is the one schedule that has been tested as safe and effective for children.

We do not follow any alternative vaccination schedules, as the safety and efficacy of these schedules has not been verified. We require all patients to be vaccinated in accordance with the CDC schedule, unless there is a medical contraindication to vaccines, which is very rare and will be discussed on a case-by-case basis. Our doctors have seen serious and fatal infectious diseases eradicated by vaccines, and we believe vaccines are one of the most important public health improvements of the last century.

We also strongly believe in the safety of vaccines and provide the same vaccines on the same schedule to our own children.

Important Insurance Coverage Information for all Expecting or New Parents

Once your baby is born, you must call your insurance company as soon as possible to add your newborn to your insurance policy, starting on his or her birthdate.

In the past, an insurance company would cover the newborn under the mother's policy for the first 30 days of life. Unfortunately, they no longer do so, but rather require that your baby be added individually to the plan.

If you fail to add your infant to your insurance policy, your baby will be considered uninsured. Doctor's visits will be billed without insurance, and you will need to pay out-of-pocket for your baby's visit to any physician.

My Insurance Card, Not Again…?

There is a method behind the madness of our requirement of presenting your insurance card for each child each time you come to our office. Even we as doctors have to present our card each time our own kids come in!

Here's a brief primer on "insurance cards" to help you understand what's going on:

- First, we sign a contract with each insurance plan we accept. These contracts state that we must check the insurance cards at each visit. By checking the numbers and address on the card, we'll send your claim to the correct company and not delay the processing of your bill, therefore, you won't get surprised by a very large bill.

- Second, sometimes despite the fact that you are still with the same job and the same insurance company, something has changed either with the plan and/or the card (such as the billing address or co-payment amount). We always check these cards against the information in our computer to make sure there are no changes. Again, this ensures you are not stuck with the bill!

- Another situation we frequently encounter is blended families. We have families with three children on three totally different insurance plans, or two children with insurance and one without insurance in the same family. Therefore, we need to see the card for each child.

We hope that this helps you better understand why we ask for your card at each visit. By knowing that we expect the card at each visit, the reason why, and quickly providing us with your insurance card (or making sure your other family members or babysitters have the card if they bring the children), we can keep our office efficiently running and file your claims in a speedy fashion.

Please contact our office should you have any questions. Thanks for your cooperation.

Children's Healthcare of Atlanta
STRONG4LIFE

What you need to know about
Feeding your 1-month-old

QUESTIONS TO ASK AT YOUR BABY'S 1-MONTH VISIT:

- How do I know if my baby is hungry?
- How do I know if my baby is full?
- Is my baby eating enough?

FIND ALL OF THIS and more at Strong4Life.com/baby

1 LEARN YOUR BABY'S HUNGER AND FULLNESS CUES.

All babies are born with natural, internal cues that let them know when they are hungry or full and exactly how much breastmilk or formula to drink. Babies use these cues to communicate and to let us know what they need. Learning your baby's cues can help you respond to his needs more quickly, which can lead to a happier, healthier baby.

HUNGER CUES:

Making sucking noises or sucking on his hands

Opening his mouth when touched on the chin, cheek or lips (called rooting)

Crying or fussing*

**Not all crying or fussiness means your baby is hungry.*

FULLNESS CUES:

Starting to suck less or letting milk run down his mouth

Unlatching from the breast or releasing the bottle nipple

Sealing his lips closed, turning attention away from the breast or bottle, or falling asleep

2 CRYING IS YOUR BABY'S WAY OF GETTING YOUR ATTENTION.

Right now, crying is your baby's main form of communication. And while crying or fussing can mean your baby is hungry (if he is displaying other hunger cues), it could also mean a lot of other things. For example, he could be crying because he's too hot or too cold, he's tired, he needs a diaper change or he just needs to be comforted. As you learn your baby's hunger cues, it will become easier to know what he's trying to tell you with each cry.

3 SUCKING IS GOOD FOR YOUR BABY.

Babies love to suck, even when their tummies are full. Sucking helps with your baby's digestion and to keep him calm. If your baby's cues tell you that he is full but he keeps sucking, consider giving him a pacifier or allowing him to suck on his own fingers.

If you are breastfeeding, only consider a pacifier once breastfeeding is well-established.

4 BREASTMILK OR IRON-FORTIFIED FORMULA IS ALL YOUR BABY NEEDS.

Breastmilk and iron-fortified formula are designed to provide the nutrients and the right amount of fluid your baby needs. Breastmilk and formula are digested quickly, so you can expect to feed your baby every two to three hours.

How much should you feed your baby?

- Pay attention to your baby's hunger and fullness cues to help guide how much you feed him.
- It is normal for your baby to eat a different amount at each feeding, even if that means he doesn't finish the whole bottle.
- Trust that your baby knows how much he needs to eat.

Did you know?

Your body knows what nutrients your baby needs, and your breastmilk changes to provide the right balance.

What to expect next:

- Over the next couple of months, it is important to start a routine for feeding, sleeping and playtime. Routines help give your baby a sense of security and help him adjust to his new world. Be patient and flexible, and use your routine as a guide as you learn your baby's cues.
- Your baby's tiny digestive system will only be able to handle breastmilk or iron-fortified formula until he is four to six months old. It is best to wait until your baby's digestive system and kidneys are more developed before adding anything other than breastmilk or iron-fortified formula. The American Academy of Pediatrics recommends vitamin D supplementation for all breastfed babies. If you have questions, talk with your baby's doctor.

Doctor's notes:

Vitamin D

- Vitamin D plays a critical role in calcium absorption and bone growth. It prevents rickets (a serious bone disorder) and likely reduces the risk of adult osteoporosis.
- Vitamin D is involved in the immune system and may help prevent other serious disorders in adults.
- Vitamin D is synthesized via sunlight as well as absorbed in the gut; however, many people are deficient due to low sun exposure and the poor bioavailability of vitamin D.
- Infants are at risk for vitamin D deficiency. Breast milk contains little vitamin D, and formula volume does not usually meet daily requirements for vitamin D. Additionally infants have appropriately limited sun exposure, which reduces vitamin D synthesis.
- For these reasons, we recommend vitamin D supplementation in all age groups.

Recommended Vitamin D Supplementation

Age	Vitamin D Amount	Supplement options
Infant *(breastmilk or formula fed)*	400 IU	-D-vi-sol, Poly-vi-sol, Tri-vi-sol (or generic equivalent) - 1 ml daily -Vitamin D drops - 1 drop per day
1 yo - 2 yo	600 IU	-D-vi-sol, Poly-vi-sol, Tri-vi-sol (or generic equivalent) - 1 ml daily -Vitamin D drops - 1 drop per day + Dietary sources
3 yo and up	600 IU	-Chewable vitamin or swallowed tablet (age dependent) + Dietary sources

- **Dietary sources and other recommendations**
  - Vitamin D
    - Oily fish (i.e. salmon, sardines, tuna, mackerel, herring), egg yolks, fortified dairy
    - The recommended milk intake for children age 1-9 years old is 16 oz.
  - Calcium
    - Milk and dishes made with milk, cheeses, yogurt, canned fish (sardines, anchovies, salmon), dark-green leafy vegetables (kale, mustard greens, collard greens etc.), broccoli
    - Adolescents and teens need additional calcium and may need calcium supplements. The recommended daily intake is 1200-1500 mg calcium per day. If your teen has less than 4 servings of calcium daily, add a calcium supplement such as Viactiv, Oscal, or Caltrate.
    - Avoid excess salt as too much salt in the diet will increase the amount of calcium excreted out of the body through the kidneys.

Iron (Fe)

Iron helps with growth and brain development. A baby is born with iron stores that last until about 4 months old. After that, iron stores are depleted, and it is necessary to provide iron supplementation and/or iron rich foods.

Recommended Iron Supplementation

Age	Iron (Fe) Amount	Supplement options
4 mo - 12 mo *breastfed*	~6-11 mg/day	-Poly-vi-sol with Fe - 1 ml daily (10 mg Elemental Fe) + Dietary sources + Ok to stop Poly-vi-sol with Fe once dietary intake meets iron requirements
4 mo - 12 mo *formula fed*	~6-11 mg/day	-24-32 oz formula per day meets iron requirements + Dietary sources
1 yo -14 yo	7 -10 mg/day	+ Dietary sources
>14 yo boy	11 mg/day	+ Dietary sources
>14 yo girl	15 mg/day	-May require iron supplement due to heavy periods + Dietary sources

- **Dietary Sources and other recommendations**
  - Infants: Iron-fortified infant cereal, pureed meats, green beans, peas, spinach
    - Infants taking Poly-vi-sol with Fe do not need a separate vitamin D supplement.
  - Children and adolescents: Fortified breakfast cereal, fortified oatmeal, meat, tofu, spinach, beans. Three serving per day of iron-containing foods should meet daily iron requirements. Read the labels on packaging to check iron content on common foods.
  - Foods high in vitamin C (citrus, strawberries, tomatoes, dark green veggies) enhance iron absorption.
  - Limit cow's milk consumption to less than 20 oz per day as more than this can increase risk of iron deficiency. Infant's under one should primarily drink breast milk or formula.
  - Menstruating females should also take folic acid, which can be found in most multivitamins. Folic acid is a B vitamin and recommended daily dosing is 400 mcg.
  - An over-the-counter multivitamin is not recommended for a child who receives a normal, well-balanced diet.

Tips for Freezing & Refrigerating Breast Milk

American Academy of Pediatrics Guide to Storing Fresh Breast Milk

Place	Temperature	How Long	Things to Know
Countertop, table	Room temp (up to 77°F)	Up to 4 hours is best. Up to 6 to 8 hours is okay for very cleanly expressed breast milk.	• Store breast milk in small batches. 2 to 4 ounces is recommended to prevent waste. • Any remaining breast milk left in a bottle after your baby is finished with a feeding should be used within 2 hours, or, if quickly refrigerated, used for the next feeding. You can always thaw an extra bag if needed.
Refrigerator	39°F or colder	Up to 4 days is best. Up to 8 days is okay for very cleanly expressed breast milk.	• Store breast milk in the back of the refrigerator. • To warm breast milk from the refrigerator, place the bottle in a bowl of warm water or run it under warm water. Heating breast milk in microwaves is not safe.
Freezer	0°F or colder	Up to 9 months	• Store breast milk toward the back of the freezer. • Breast milk expands as it freezes, so do not fill the milk all the way to the top of the storage container. • To thaw breast milk from the freezer, put the bottle or bag in the refrigerator overnight, hold it under warm running water, or set it in a container of warm water. Heating breast milk in microwaves is not safe. • Once breast milk is thawed, it can be stored in a refrigerator and must be used within 24 hours.
Deep freezer	-4°F or colder	Up to 12 months	• Store breast milk toward the back of the deep freezer. • Breast milk expands as it freezes, so do not fill the milk all the way to the top of the storage container. • To thaw breast milk from the deep freezer, put the bottle or bag in the refrigerator overnight, hold it under warm running water, or set it in a container of warm water. Heating breast milk in microwaves is not safe. • Once breast milk is thawed, it can be stored in a refrigerator and must be used within 24 hours.

Editor's Note: *Although these breast milk storage guidelines are appropriate for babies born premature and those who are hospitalized, hospitals may have their own rules. If you have specific questions, discuss these guidelines with your baby's pediatrician and/or hospital.*

Where We Stand:

The American Academy of Pediatrics recommends breastfeeding as the sole source of nutrition for your baby for about 6 months. When you add solid foods to your baby's diet, continue breastfeeding until at least 12 months. You can continue to breastfeed after 12 months if you and your baby desire.

Author: Dina DiMaggio, MD, FAAP
Last Updated: 9/9/2016

Go Back to Work and Continue to Breastfeed? Yes, You Can!

Start Planning Now

Ask any mother working outside the home: Juggling family and job responsibilities is a daily balancing act. Mothers with brand new babies face even greater challenges. The longer you are able to stay home the better. However if you are getting ready to return to work shortly after the birth of your baby, you might be concerned about how to continue to breastfeed. Don't worry. With some advance planning, it is possible to successfully combine work and breastfeeding .

Why Continue to Breastfeed?

Health authorities such as the Surgeon General and the American Academy of Pediatrics agree that breastmilk offers superior infant nutrition. In addition, breastfed babies have significantly fewer respiratory-tract and ear infections than bottle-fed babies. Breastfeeding reduces an infant's risk of food allergy, and initial research suggests that breastfeeding may have a long-term positive effect on baby's immune system.

For mothers, breastfeeding helps the uterus return to its pre-pregnancy state more quickly. And with no formula or vitamin costs, breastfeeding is more convenient and less expensive than bottle feeding.

How Will You Combine Breastfeeding with Working?

Create Employer Awareness

Fortunately, more and more employers are realizing the critical role women play in the work force and are taking steps to make it easier for them to return to the job and continue to breastfeed.

Some progressive employers institute company-sponsored support for breastfeeding mothers. For example, a Sanvita® Corporate Lactation Program includes prenatal education and postnatal counseling provided by an on-site lactation professional, as well as time, space and equipment for women to pump their breastmilk at work. Other companies may not have a full-fledged program, but will allow women to take the time they need during the day to pump their breastmilk.

Talk with your employer before your baby is born. You may want to extend your maternity leave, work part-time for a period, job share, or work at home part of each day or week. If your company does not have a Lactation Program, now may be the time to investigate starting one. In lieu of a formal program, however, try to make your own arrangements.

Explain to your employer the health benefits of breastfeeding for your baby. When baby is sick, mother often must be absent from work. The prospect of less absenteeism among breastfeeding mothers is a bonus for cost-conscious employers.

Select a Caregiver

Choosing the person who will care for your baby while you are at work is an important decision. You will want to select someone who supports your commitment to breastfeeding. Don't wait until the last minute to start investigating your choices. You will need to find a primary person as well as several back-ups—just in case.

Give your caregiver explicit written instructions on how to store breastmilk. Explain that, if possible, your baby should not be fed within a couple hours of your return. That way, he or she will be ready to breastfeed as soon as you arrive at the caregiver's after work. If baby is hungry before you arrive, the caregiver should tide him or her over with some water or a snack-sized portion of stored breastmilk.

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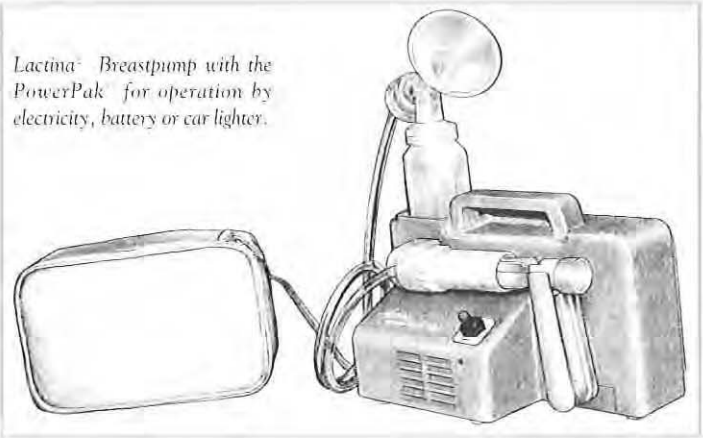
Contributions made by The Breastfeeding Connection and Sanvita® Programs.



Lactina® Breastpump with the PowerPak® for operation by electricity, battery or car lighter.

Helpful Hints for Breastfeeding

- Take full advantage of your maternity leave to establish a good supply of milk before going back to work.

- Once your milk is well-established and your baby is nursing well (at about 4 to 6 weeks), introduce a bottle. This step prepares your baby for bottle feeding during the day while you are at work. Keep in mind that babies usually associate breastfeeding with mom. Consequently, in the beginning, some babies are more receptive to a bottle if it is offered to them from someone other than you.

- Purchase or rent a high-quality, automatic, electric breast pump. For example, Medela's Lactina® is state-of-the-art in performance, safety and convenience. It runs on regular electricity or can be battery-operated. It also can be powered by a vehicle battery via a cigarette lighter connector. Other smaller pumps may not be able to maintain your milk supply on a long term basis.

- Use a double-pumping kit with your electric breast pump. By expressing both breasts simultaneously, most mothers can complete a pumping session in just 10 to 15 minutes, which easily fits into a break period or lunch time.

Breastmilk availability works on a supply and demand basis. Maintaining a good milk supply depends on the regular stimulation provided by baby or by pumping. Double pumping increases your prolactin levels, which helps maintain milk supply. This benefit is important to working mothers who might have difficulty maintaining their milk supply because baby isn't always available for breast stimulation.

- To familiarize yourself with the process and help build up milk supply, start using your electric breastpump about one to two weeks before you return to work. Try to simulate what your pumping schedule will be at work.

- To ease your transition back to work, try to return midweek so that you have only a few days before the weekend. Plan to breastfeed at least once before you leave in the morning. If you can, go home or to your daycare facility at lunch time to breastfeed, or have your baby brought to you. If breastfeeding during the lunch hour is not possible, plan to pump two to three times during the day at work. (Remember, if you are using a double-pumping kit, that's just about 45 minutes out of your work day.)

Breastfeed as soon as you can after you return home or reach the day care facility, during the evening, before bed, and on weekends as often as possible. Depending on your baby's age and the amount of time you spend away from him or her, you might be able to reduce the number of pumping sessions at work to one or two times a day.

- If your company does not make a special room available for mothers who are breastpumping, find a spot that is as private and comfortable as possible. Bring along a picture of your baby, something to drink and perhaps a small snack. If you have difficulty letting down, take a few deep breaths, listen to some soothing music or imagine your baby nursing.

- You can store the milk you pump each day so that it is available for your baby the following day while you are at work. If a refrigerator is not available, use a cooler case. Medela offers a number of options, including a soft-sided carrying case for the Lactina Breastpump with a built-in cooler.

Human milk can be kept in the refrigerator for up to 72 hours. If you must keep it longer than 72 hours, label the bottles with the date and store them in a home freezer. breastmilk will keep in the freezer for six months. Thaw frozen milk in warm water; do not microwave or boil it.

You Can Do It!

It is typical for any new mother returning to work to feel fatigued and to experience a sense of loss over leaving her new baby in someone else's care. If you have been breastfeeding your baby, you may feel even more sadness at the prospect of having to cease a natural process that has protected your infant's health and created such a powerful, nurturing bond between you and your baby.

These kinds of reactions to stopping breastfeeding before you really want to are quite normal. The good news is that you don't have to stop. Pumping your breastmilk at work will maintain your milk supply so that you can continue to breastfeed mornings, evenings and on weekends—until you and your baby are ready to wean.

You'll need some patience to get through a period of adjustment. You'll need some practice with the pump. And of course, it helps to have an understanding employer. But the choice is yours. Return to work and continue to breastfeed. Yes, you can!

*Naturally, with a little help from a friend™...***medela®**

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Bottle Feeding Basics

The most obvious difference between bottle-feeding and breastfeeding is that the bottle lets you see how much your baby is drinking. Depending on what kind of parent you are, this may make you feel better because you know what your baby is getting, or it may give you something new to obsess about. Whenever you read guidelines for bottle-feeding, remember that each baby is different. Bigger babies need more food. Your baby may go through a growth spurt and seem hungry all the time, and then she may have a period when she eats less for a while. In general babies know how much food they need to grow. If you attend to your baby's hunger cues, she'll tell you how much food she wants and when she's full.

Choosing A Bottle

Choosing a bottle can be as challenging as picking a formula. Manufacturers make all sorts of claims about their nipples working more like the human breast or their bottles preventing gas. I haven't seen good scientific literature that supports these claims, so I can't recommend one brand over another.

How Many Ounces?

Just like breastfed babies, bottle-fed newborns may start off slowly for 2 to 3 days, often taking only 1 to 2 ounces (30–60 mL) at a time. After the first 2 to 3 days of life she'll probably be taking 2 to 3 ounces (60–90 mL) every 3 to 4 hours. Sometimes your baby may sleep 4 to 5 hours between bottles, but she'll need a lot of food over the first month or so of life, so if she hasn't awakened to eat after 5 hours it's a good idea to go ahead and wake her up. You might even consider waking her up after 3 or 4 hours during the daytime, hoping she'll sleep a little longer at night.

After the first month of life your infant is likely to take around 4 ounces from the bottle every 4 hours or so, at least on average. That intake rises gradually so that by age 6 months, she'll take 6 to 8 ounces (180–240 mL) 4 or 5 times a day. Another way to think about normal intake is by weight; for every pound of body weight, your infant will consume around 2½ ounces (75 mL) per day. That said, every baby is different, and her doctor will weigh and measure her at each wellness examination to assess whether her growth is appropriate for her age.

Hunger Cues

Whether you're breastfeeding or bottle-feeding, your baby will give the same cues to let you know when she's hungry and when she's full. She will start rooting, scooting, sucking on her hand, and smacking her lips when she needs food. She will release the nipple, turn away, and often fall asleep when she's full. As she grows she may fall asleep less often and instead look up and grin at you. You can be pretty confident at this point that the feeding is over, especially if she's letting formula drip on your pants.

Feeding FAQs

The 3 most common questions I answer about feeding, no matter the source, are:

- "Is she getting enough?"
- "Is she getting too much?"
- "When will she stop waking up at night to feed?"

The first question we've already answered. As for too much, it's rare for a baby to need more than about 7 or 8 ounces per feeding or more than 36 ounces in a day. She may be sucking for comfort rather than hunger. As for the last question, most babies will be able to make it through the night without feeding sometime between age 2 and 4 months or when they weigh more than about 12 pounds. That really unfamiliar, energetic feeling you'll have? It's called a full-night's sleep.

What You Can Do

More important than the type of bottle or nipple you use is how you position your baby when she eats. You'll want to support her in a semi-upright position, with her head cradled in the crook of your arm. Hold the bottle so that milk completely covers the nipple; that way your baby isn't swallowing air. Try not to bottle-feed your baby while she's on her back. Lying down increases the risk that she'll choke, and it allows milk to run into her eustachian tubes, possibly causing middle ear infections. In the first few weeks of life you may have to gently touch the nipple to her cheek to stimulate the rooting reflex.

When to Call the Doctor

Overfeeding often results in spitting up and contributes to obesity. If your baby is taking more than 7 or 8 ounces per feeding or more than 36 ounces a day, address it with her doctor.

Author David L. Hill, MD, FAAP
Last Updated 11/21/2015
Source: Dad to Dad: Parenting Like a Pro (Copyright © American Academy of Pediatrics 2012)

Forms of Baby Formula: Powder, Concentrate & Ready-to-Feed

Infant formulas generally come as ready-to-feed liquid, concentrated liquid, and powder. Which type is going to work best for you is likely to depend on how much formula you plan to use, where you plan to use it, and how much you want to spend.

Start Thinking in Ounces:
Bottle-feeding your baby will require you to think in ounces and adopt it as your standard unit of measurement.

Here are the basic measurements you'll need for formula success.

- 1 ounce = 30 cc (cubic centimeters) = 30 mL (milliliters)
- 8 fluid ounces = 1 cup
- 32 fluid ounces = 1 quart

Formula Prep by Form:

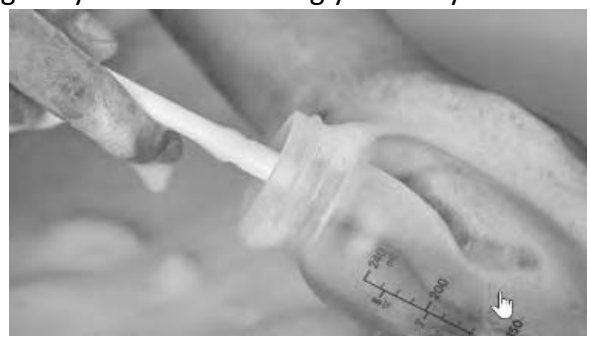
- **Powder.** The simple concept here is that you add powder to premeasured water and shake a lot. In what we can only assume was an enlightened attempt to eliminate room for mixing errors, most powdered formula is mixed according to the same recipe: *1 scoop of powder to every 2 fluid ounces of water.* Powdered formula comes in cans containing enough powder to make anywhere from 90 ounces to more than 200 ounces of prepared formula. It is certainly your most economical choice, and quite frankly works perfectly well for most babies. You can decide whether to mix it up as you go or prepare a full day's worth at a time and refrigerate it.
- **Liquid concentrate.** This is the "just add water as directed and shake" formula option. Mixing and measuring is again quite straightforward, because all brands of concentrate call for equal amounts of water and concentrate. If you intend to end up with a total of 4 fluid ounces of prepared formula, you'll need to mix 2 fluid ounces of concentrate with 2 fluid ounces of water. Of course, many people choose to mix an entire can of concentrate (13 fluid ounces) with an equal amount of water. The resulting 26 fluid ounces of now-ready-to-feed formula can be covered and put in the refrigerator to be used over the next 48 hours. While some parents find concentrate to be easier, neater, and/or more convenient than powder, it is a convenience for which you will pay more.
- **Ready-to-feed.** This is your no-mixing, no-measuring, no-mess option. Typically sold in 2-,6-or 8-fluid-ounce containers (with anywhere from 4 to 24 to a pack) or 1-quart (32-fluid-ounce) containers/cans, the use of ready-to-feed formula is hopefully self-explanatory—what you see is what you give. While the fairly small "Ready-to-Feed" caption isn't always prominently displayed on the label, you'd be hard pressed to miss the distinguishing price tag. While buying ready-to-feed formula inevitably costs the most, it leaves almost no room for error (assuming that you don't mistake it for concentrate and dilute it with water). It also happens to be the easiest way to limit your newborn's exposure to too much fluoride. Unopened cans can be conveniently stored at room temperature. Once opened, unused portions can be covered and then refrigerated for up to 48 hours.

Last Updated: 8/7/2018
Source: Heading Home With Your Newborn, 2nd Edition (Copyright © 2010 American Academy of Pediatrics)

How to Sterilize and Warm Baby Bottles Safely

Parents and pediatricians today are not as concerned with sterilizing bottles and water as they were a generation ago, but many are now having second thoughts in light of recent reports of contaminated city water supplies and increased concern over food safety.

- For starters, always wash your hands before handling baby bottles or feeding your baby.
- If you use disposable plastic bottle liners and ready-to-use formula, you still need to make sure the nipples are clean. Scrub them in hot, soapy water, then rinse to get rid of all traces of soap; some experts recommend boiling them for 5 minutes.
- Always wash and thoroughly rinse and dry the top of the formula can before you open it; make sure the can opener, mixing cups, jars, spoons, and other equipment are clean.



Glass Bottles & Formula Safety

If you use regular glass bottles and concentrated or powdered formula, you must make sure that the bottles and water added to the formula are germ free. You don't need to boil the bottles; you can put them, along with mixing cups and other equipment used to prepare formula, in a dishwasher that uses heated water and has a hot drying cycle. Or you can wash the bottles in hot, soapy water and rinse thoroughly. This alone should kill most germs.

Mixing with Water

Water for mixing infant formula must be from a safe water source as defined by the state or local health department. If you are concerned or uncertain about the safety of tap water, you may use bottled water or bring cold tap water to a rolling boil for 1 minute (no longer), then cool the water to room temperature for no more than 30 minutes before it is used. Warmed water should be tested in advance to make sure it is not too hot for the baby. The easiest way to test the temperature is to shake a few drops on the inside of your wrist. Otherwise, a bottle can be prepared by adding powdered formula and room-temperature water from the tap just before feeding. Bottles made in this way from powdered formula can be ready for feeding because no additional refrigeration or warming would be required.

Storing Prepared Formula

- Prepared formula must be discarded within 1 hour after serving a baby.
- Prepared formula that has not been given to a baby may be stored in the refrigerator for 24 hours to prevent bacterial contamination.
- An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, and discarded after 48 hours if not used.

Last Updated: 8/7/2018

Baby's First Days: Bowel Movements & Urination

Urination

Your baby may urinate as often as every one to three hours or as infrequently as four to six times a day. If she's ill or feverish, or when the weather is extremely hot, her usual output of urine may drop by half and still be normal. Urination should never be painful. If you notice any signs of distress while your infant is urinating, notify your pediatrician, as this could be a sign of infection or some other problem in the urinary tract.

In a healthy child, urine is light to dark yellow in color. (The darker the color, the more concentrated the urine; the urine will be more concentrated when your child is not drinking a lot of liquid.) Sometimes you'll see a pink stain on the diaper that you may mistake for blood. In fact, this stain is usually a sign of highly concentrated urine, which has a pinkish color. As long as the baby is wetting at least four diapers a day, there probably is no cause for concern, but if the pinkish staining persists, consult your pediatrician.

The presence of actual blood in the urine or a bloody spot on the diaper is never normal, and your pediatrician should be notified. It may be due to nothing more serious than a small sore caused by diaper rash, but it also could be a sign of a more serious problem. If this bleeding is accompanied by other symptoms, such as abdominal pain or bleeding in other areas, seek medical attention for your baby immediately.

Bowel Movements

Beginning with the first day of life and lasting for a few days, your baby will have her first bowel movements, which are often referred to as meconium. This thick black or dark-green substance filled her intestines before birth, and once the meconium is passed, the stools will turn yellow-green.

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

Whether your baby is breastfed or bottle-fed, hard or very dry stools may be a sign that she is not getting enough fluid or that she is losing too much fluid due to illness, fever, or heat. Once she has started solids, hard stools might indicate that she's eating too many constipating foods, such as cereal or cow's milk, before her system can handle them. (Whole cow's milk is not recommended for babies under twelve months.)

Here are some other important points to keep in mind about bowel movements:

- Occasional variations in color and consistency of the stools are normal. For example, if the digestive process slows down because the baby has had a particularly large amount of cereal that day or foods requiring more effort to digest, the stools may become green; or if the baby is given supplemental iron, the stools may turn dark brown. If there is a minor irritation of the anus, streaks of blood may appear on the outside of the stools. However, if there are large amounts of blood, mucus, or water in the stool, call your pediatrician immediately. These symptoms may indicate an intestinal condition that warrants attention from your doctor.
- Because an infant's stools are normally soft and a little runny, it's not always easy to tell when a young baby has mild diarrhea. The telltale signs are a sudden increase in frequency (to more than one bowel movement per feeding) and unusually high liquid content in the stool. Diarrhea may be a sign of intestinal infection, or it may be caused by a change in the baby's diet. If the baby is breastfeeding, she can even develop diarrhea because of a change in the mother's diet.
- The main concern with diarrhea is the possibility that dehydration can develop. If fever is also present and your infant is less than two months old, call your pediatrician. If your baby is over two months and the fever lasts more than a day, check her urine output and rectal temperature; then report your findings to your doctor so he can determine what needs to be done. Make sure your baby continues to feed frequently. As much as anything else, if she simply looks sick, let your doctor know.

The frequency of bowel movements 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 whenever the stomach is filled with food.

By three to six weeks of age, some breastfed babies have only one bowel movement a week and still are normal. This happens because 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 as long as the stools are soft (no firmer than peanut butter), and your infant is otherwise normal, gaining weight steadily, and nursing regularly.

If your baby is formula-fed, she should have at least one bowel movement a day. If she has fewer than this and appears to be straining because of hard stools, she may be constipated. Check with your pediatrician for advice on how to handle this problem.

Last Updated: 8/1/2009
Source: Caring for Your Baby and Young Child: Birth to Age 5 (Copyright © 2009 American Academy of Pediatrics)

With Your Baby, Make Sure It's Safety First!

Each year, hundreds of children die from preventable accidents. Babies are fast learners when it comes to rolling, crawling, grasping, sitting, standing and then walking. There is a reason one whole aisle at the Baby Super Store is devoted to safety.

Here are some tips for keeping your home safe:

- **Water heater:** Ensure your water heater is set no higher than 120 degrees Fahrenheit. This will help to ensure water from the faucet does not lead to burns during bathing, handwashing, etc.
- **Smoke detectors:** Keep a smoke alarm on every level of your home and test the alarms at least twice a year (daylight savings time is a good time to remember). Use long-life batteries so they only need to be changed once a year.
- **Carbon monoxide detectors:** Carbon monoxide is an odorless gas and can be deadly. Your home should have these detectors as well.

Babies love to explore. They learn new skills to do this very quickly!

Here are some tips for keeping your infant safe from more dangers:

- **Rolling and falling:** Always keep an eye (and hand) on your newborn and infant. Rolling off beds, couches and changing tables happens very quickly so never leave your baby alone.
- **Burns and scalds:** Children also love to grab at everything starting around 4-6 months. Never leave hot cups of coffee, tea or other liquids near table or counter edges. Do not carry hot liquids while holding or walking with your baby. Keep your baby in an enclosed safe area or playpen while cooking or when you can't keep your FULL attention on them.
- **Choking**: Make sure all small objects and toys are out of your baby's reach, especially if you have older children. Babies explore their world by putting objects in their mouths. As you introduce new foods at age 4-6 months, small food items such as nuts, popcorn, grapes, hot dogs etc. will be potential choking hazards and should be avoided. Finally, learning infant and child CPR is an excellent and empowering idea for all parents.
- **Honey**: Please do not offer your newborn or infant any raw or baked honey until **after** age 1 year. Honey is a potential source of a bacteria called *Clostridium botulinum*. This bacteria can cause botulism if disease-causing spores are ingested. Botulism can be a very serious and rapidly progressive disease that can cause the nerves to function abnormally leading to weakness, paralysis and even death.

Siblings

Welcoming a new baby to the home is a
joyous time but can be overwhelming for everyone.

Below are some tips to smooth the transition for brothers and sisters:

Talk about it! Parents get 9 months to mentally prepare for another little one, so make sure your toddler has the same chance to acclimate. Talk about what having a baby in the house might be like and what changes to expect. Will he be promoted to a big kid bed? Will sitting in mommy's lap be shared with the new baby? Reading books together about becoming a big sister or brother or visiting friends with infants > 2 months old can also introduce the new role.

Practice makes perfect. Let big brother or sister care for a baby doll. Show him safe practices such as baby sleeping on her back and gently holding and soothing baby. This baby doll also comes in useful once the real deal arrives. Your toddler can feed her baby doll right next to you (keeping her occupied while you're tied up!).

Real responsibilities. Have you noticed that your toddler loves to be helpful? Find ways to let your toddler truly contribute to caring for baby. Create a "diaper bag" for your toddler to be in charge of, stocked with diapers, wipes and a burp cloth. When it is time for a diaper change, have your toddler bring his big kid diaper bag and hand you the needed supplies.

One step forward, two steps back. Some kids will show signs of regression (toilet training accidents, not sleeping through the night, tantrums) after a new baby arrives. Remember these backslides are common and likely temporary as your toddler adjusts to having a new baby at home. With that in mind, avoid tackling major milestones (such as potty training, discontinuing thumb sucking) around the time of baby's due date.

Time management. A new baby is certainly time consuming, but try to set aside dedicated "Big Kid Time" for the older children as well. Just 15 minutes of individual story time, a quick park trip, or craft project, can go a long way in minimizing melt-downs and jealousy. Focused big brother or sister time reminds them of their importance to the family.

Safety first! Limit spread of viruses from your toddler with good handwashing. Encourage your toddler to touch or kiss baby's tiny toes instead of her face or nose. Older children may be able to hold baby when sitting on the couch, but should be closely supervised.

Outnumbered? A growing family means splitting attention between multiple kids of different ages. Recognize that toddlers and even elementary school kids still need close supervision, and you may need adult back up to help out (especially in the early sleep deprived days)!

Baby Heart Rate and Oxygen Monitoring

All your friends have them…
People on Facebook swear they have saved their cousin's baby…
You got one as a baby shower gift…

What is true when it comes to the new "smart" baby monitors such as the Owlet? Are they as smart as their glossy websites and brochures state?

- If you look closely at the "fine print" on their websites, the companies disclose that these devices are "not to be used as medical devices," so they have not undergone the rigorous testing medical devices undergo to show they are useful.

- Studies in true medical journals have shown these monitors do **not** provide any increase in safety vs children who don't use them, and provide a false sense of security to parents who use them.

- Another thing we see is the alarms often go off when there are no problems and keep the parents up at night, or coming to the doctor's office (where they may catch germs) for unwarranted reasons.

What does work to avoid sudden infant death syndrome (SIDS)?

- First, always place your infant on their back to sleep! By promoting infants sleeping on their backs over the last two decades, SIDS has decreased by almost 70%.

- Second, cribs for infants and babies should be boring: no toys, stuffed animals, blankets, pillows, or bumpers in the crib. Also, no co-sleeping should be done in mom and dad's bed, or on the couch or chairs with caretakers.

- Finally, breast feeding and not smoking wrap up ways that help infants avoid SIDS. Save your money for the college fund and avoid buying items which won't help protect your baby like these monitors. Do the things we do know help avoid SIDS like the above items.

Let us know if you have any further questions!

4/2017

Taking a Rectal Temperature

Very few babies get through infancy without having a fever, which is usually a sign of infection somewhere in the body. A fever indicates that the immune system is actively fighting viruses or bacteria, so in this respect, it is a positive sign that the body is protecting itself.

An infant or toddler cannot hold a thermometer in his mouth for you to take an oral temperature, and "fever strips" that are placed on the child's forehead are not accurate. The best way to measure fever in a young child is by taking a rectal temperature. Once you know how to take a rectal temperature, it is really quite simple; but it's best to learn the procedures in advance so you're not nervous about them the first time your child is actually sick.

How to Tale a Rectal Temperature

The procedure for taking a rectal temperature with a digital thermometer is as follows:

1. Clean the end of the thermometer with rubbing alcohol or soap and water. Rinse with cool **(not hot)** water.
2. Apply disposable plastic sleeve.
3. Place a small amount of lubricant such as petroleum jelly on the end.
4. Place your child belly-down across your lap or on a firm surface. Hold your child steady by placing your palm against his lower back, just above his bottom.
5. With the other hand, turn on the thermometer's switch, and then insert the thermometer one-half to one inch into the anal opening. **(Do not insert it any farther.)** Hold the thermometer loosely in place using two fingers, while keeping your hand cupped around your child's bottom.
6. Hold the thermometer in place for about one minute, until you hear it beep.
7. Remove the thermometer and check the reading. Most digital thermometers come with disposable sleeves to cover the thermometer; once you've taken your baby's temperature, dispose of this plastic sleeve. Use a clean one next time you use the device.

A rectal reading over 100.4^{o} Fahrenheit (38^{o} Celsius) may indicate a fever. Retake the temperature in thirty minutes if you think the temperature may be unusually high because your child has been physically active or too warmly clothed. If your baby is younger than two months of age, contact your pediatrician right away if his temperature is 100.4^{o} Fahrenheit (38^{o} Celsius) or higher.

Excerpted from Caring for Baby and Young Child: Birth to Age 5, Bantam 2005
Page 66-67, 70; Steven P Shelov, MD, Editor-in-Chief

Your Newborn and Fever

Your newborn is not nearly so fragile as you might think. However, there are a few precautions you should take to avoid illness in the first few months of life.

For the first few weeks we suggest you be a “homebody”. This will give you a chance to get to know your baby’s usual routine (as well as a chance to recuperate yourself). Limit visitors to healthy adults and make everyone wash hands before holding or touching the baby. Also Tdap should be up-to-date for any family members and caregivers that will be around the newborn. After this period of getting acquainted you can get out with the baby, but we still suggest you avoid crowds, sick people and cigarette smoke.

Should your baby become ill in the first 12 weeks or so, we are available to discuss any symptoms of concern. Fever, though, is a symptom we must hear from you about immediately. During the first 12 weeks, fever is a rectal temperature over 100.4^{o} (without adding or subtracting, please!). Rectal temperatures are the most reliable means of taking your newborn’s temperature. Directions for taking a rectal temperature are on the back. We recommend a digital rectal thermometer; tympanic (ear) thermometers are not very reliable in children less than 6 months.

If you have any questions, feel free to discuss them with your doctor or nurse.

How to Keep Your Sleeping Baby Safe: AAP Policy Explained

More than 3,500 babies in the U.S. die suddenly and unexpectedly every year while sleeping, often due to sudden infant death syndrome (SIDS) or accidental deaths from suffocation or strangulation.

In an effort to reduce the risk of all sleep-related infant deaths, the American Academy of Pediatrics' (AAP) updated policy statement and technical report includes new evidence that supports skin-to-skin care for newborn infants; addresses the use of bedside and in-bed sleepers; and adds to recommendations on how to create a safe sleep environment.

Note: All of these recommendations, unless mentioned otherwise, are for babies up to 1 year of age. Talk with your pediatrician if you have questions about any of the recommendations listed.

What You Can Do: Recommendations for Infant Sleep Safety

- **Until their first birthday, babies should sleep on their backs for all sleep times—for naps and at night**. We know babies who sleep on their backs are much less likely to die of SIDS than babies who sleep on their stomachs or sides. The problem with the side position is that the baby can roll more easily onto the stomach. Some parents worry that babies will choke when on their backs, but the baby's airway anatomy and the gag reflex will keep that from happening. Even babies with gastroesophageal reflux (GERD) should sleep on their backs.
    - Newborns should be placed skin-to-skin with their mother as soon after birth as possible, at least for the first hour. After that, or when the mother needs to sleep or cannot do skin-to-skin, babies should be placed on their backs in the bassinet. While preemies may need to be on their stomachs temporarily while in the NICU due to breathing problems, they should be placed on their backs after the problems resolve, so that they can get used to being on their backs and before going home.
    - Some babies will roll onto their stomachs. You should always place your baby to sleep on the back, but if your baby is comfortable rolling both ways (back to tummy, tummy to back), then you do not have to return your baby to the back. However, be sure that there are no blankets, pillows, stuffed toys, or bumper pads around your baby, so that your baby does not roll into any of those items, which could cause blockage of air flow.
    - If your baby falls asleep in a car seat, stroller, swing, infant carrier, or sling, you should move him or her to a firm sleep surface on his or her back as soon as possible.
- **Use a firm sleep surface.** A crib, bassinet, portable crib, or play yard that meets the safety standards of the Consumer Product Safety Commission (CPSC) is recommended along with a tight-fitting, firm mattress and fitted sheet designed for that particular product. Nothing else should be in the crib except for the baby. A firm surface is a hard surface; it should not indent when the baby is lying on it. Bedside sleepers that meet CPSC safety standards may be an option, but there are no published studies that have examined the safety of these products. In addition, some crib mattresses and sleep surfaces are advertised to reduce the risk of SIDS. There is no evidence that this is true, but parents can use these products if they meet CPSC safety standards.

- **Room share—keep baby's sleep area in the same room where you sleep for the first 6 months or, ideally, for the first year**. Place your baby's crib, bassinet, portable crib, or play yard in your bedroom, close to your bed. The AAP recommends room sharing because it can decrease the risk of SIDS by as much as 50% and is much safer than bed sharing. In addition, room sharing will make it easier for you to feed, comfort, and watch your baby.
- **Only bring your baby into your bed to feed or comfort**. Place your baby back in his or her own sleep space when you are ready to go to sleep. If there is any possibility that you might fall asleep, make sure there are no pillows, sheets, blankets, or any other items that could cover your baby's face, head, and neck, or overheat your baby. As soon as you wake up, be sure to move the baby to his or her own bed.
- **Never place your baby to sleep on a couch, sofa, or armchair**. This is an extremely dangerous place for your baby to sleep.
- **Bed-sharing is not recommended for any babies**. However, certain situations make bed-sharing even more dangerous. Therefore, you should not bed share with your baby if:
    - Your baby is younger than 4 months old.
    - Your baby was born prematurely or with low birth weight.
    - You or any other person in the bed is a smoker (even if you do not smoke in bed).
    - The mother of the baby smoked during pregnancy.
    - You have taken any medicines or drugs that might make it harder for you to wake up.
    - You drank any alcohol.
    - You are not the baby's parent.
    - The surface is soft, such as a waterbed, old mattress, sofa, couch, or armchair.
    - There is soft bedding like pillows or blankets on the bed.
- **Keep soft objects, loose bedding, or any objects that could increase the risk of entrapment, suffocation, or strangulation out of the baby's sleep area**. These include pillows, quilts, comforters, sheepskins, blankets, toys, bumper pads or similar products that attach to crib slats or sides. If you are worried about your baby getting cold, you can use infant sleep clothing, such as a wearable blanket. In general, your baby should be dressed with only one layer more than you are wearing.
- **It is fine to swaddle your baby**. However, make sure that the baby is always on his or her back when swaddled. The swaddle should not be too tight or make it hard for the baby to breathe or move his or her hips. When your baby looks like he or she is trying to roll over, you should stop swaddling.
- **Try giving a pacifier at nap time and bedtime**. This helps reduce the risk of SIDS, even if it falls out after the baby is asleep. If you are breastfeeding, wait until breastfeeding is going well before offering a pacifier. This usually takes 2-3 weeks. If you are not breastfeeding your baby, you can start the pacifier whenever you like. It's OK if your baby doesn't want a pacifier. You can try offering again later, but some babies simply don't like them. If the pacifier falls out after your baby falls asleep, you don't have to put it back in.

What Moms Can Do: Recommendations for Prenatal & Postnatal

- **Do not smoke during pregnancy or after your baby is born**. Keep your baby away from smokers and places where people smoke. If you are a smoker or you smoked during pregnancy, it is very important that you do not bed share with your baby. Also, keep your car and home smoke-free. Don't smoke anywhere near your baby, even if you are outside.

- **Do not use alcohol or illicit drugs during pregnancy or after the baby is born**. It is very important not to bed share with your baby if you have been drinking alcohol or taken any medicines or illicit drugs that can make it harder for you to wake up.
- **Breastfed babies have a lower risk of SIDS**. Breastfeed or feed your baby expressed breast milk. The AAP recommends breastfeeding as the sole source of nutrition for your baby for about 6 months. Even after you add solid foods to your baby's diet, continue breastfeeding for at least 12 months, or longer if you and your baby desire.
- **Schedule and go to all well-child visits**. Your baby will receive important immunizations at these doctor visits. Recent evidence suggests that immunizations may have a protective effect against SIDS.
- **Make sure your baby has tummy time every day**. Awake tummy time should be supervised by an awake adult. This helps with baby's motor development and prevents flat head syndrome. *See Back to Sleep, Tummy to Play for more information and ways to play with the baby during tummy time.*

Use Caution When Buying Products

- **Use caution when a product claims to reduce the risk of SIDS.** Wedges, positioners, special mattresses and specialized sleep surfaces have not been shown to reduce the risk of SIDS, according to the AAP.
- **Do not rely on home heart or breathing monitors to reduce the risk of SIDS**. If you have questions about using these monitors for other health conditions, talk with your pediatrician.
- **There isn't enough research on bedside or in-bed sleepers**. The AAP can't recommend for or against these products because there have been no studies that have looked at their effect on SIDS or if they increase the risk of injury and death from suffocation.

Additional Information & Resources:

- Sleep Position: Why Back is Best
- New Crib Standards: What Parents Need to Know
- Safe Sleep for Babies (Video)
- The Healthy Children Show: Sleep (Video)

Author: By: Rachel Y. Moon, MD, FAAP
Last Updated: 2/10/2020

Swaddling: Is it Safe?

New parents often learn how to swaddle their infant from the nurses in the hospital. A blanket wrapped snuggly around your baby's body can resemble the mother's womb and help soothe your newborn baby. The American Academy of Pediatrics (AAP) says that when done correctly, swaddling can be an effective technique to help calm infants and promote sleep .

But if you plan to swaddle your infant at home, you need to follow a few guidelines to make sure you are doing it safely.

Back to Sleep

To reduce the risk of Sudden Infant Death Syndrome, or SIDS, it's important to place your baby to sleep on his back, every time you put him to sleep. This may be even more important if your baby is swaddled. Some studies have shown an increased risk of SIDS and accidental suffocation when babies are swaddled if they are placed on their stomach to sleep, or if they roll onto their stomach, says Rachel Moon, MD, FAAP, chair of the task force that authored the AAP's safe sleep recommendations.

When to Stop Swaddling

"I would stop swaddling by age 2 months, before the baby intentionally starts to try to roll," Dr. Moon says. "If babies are swaddled, they should be placed only on their back and monitored so they don't accidentally roll over."

Know the Risks

Parents should know that there are some risks to swaddling, Dr. Moon says. Swaddling may decrease a baby's arousal, so that it's harder for the baby to wake up. "That is why parents like swaddling – the baby sleeps longer and doesn't wake up as easily," she said. "But we know that decreased arousal can be a problem and may be one of the main reasons that babies die of SIDS."

AAP Safe Sleep Recommendations

The AAP recommends parents follow the safe sleep recommendations every time they place their baby to sleep for naps or at nighttime:

- Place your baby on her back to sleep, and monitor her to be sure she doesn't rollover while swaddled.
- Do not have any loose blankets in your baby's crib. A loose blanket, including a swaddling blanket that comes unwrapped, could cover your baby's face and increase the risk of suffocation.
- Use caution when buying products that claim to reduce the risk of SIDS. Wedges, positioners, special mattresses and specialized sleep surfaces have not been shown to reduce the risk of SIDS, according to the AAP.
- Your baby is safest in her own crib or bassinet, not in your bed.

- Swaddling can increase the chance your baby will overheat, so avoid letting your baby get too hot. The baby could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and rapid breathing.
- Consider using a pacifier for naps and bedtime.
- Place the crib in an area that is always smoke-free.

Keep Hips Loose

Babies who are swaddled too tightly may develop a problem with their hips. Studies have found that straightening and tightly wrapping a baby's legs can lead to hip dislocation or hip dysplasia, an abnormal formation of the hip joint where the top of the thigh bone is not held firmly in the socket of the hip.

The Pediatric Orthopaedic Society of North America, with the AAP Section on Orthopaedics, promotes "hip-healthy swaddling" that allows the baby's legs to bend up and out.

How to Swaddle Correctly

1. To swaddle, spread the blanket out flat, with one corner folded down.
2. Lay the baby face-up on the blanket, with her head above the folded corner.
3. Straighten her left arm, and wrap the left corner of the blanket over her body and tuck it between her right arm and the right side of her body.
4. Then tuck the right arm down, and fold the right corner of the blanket over her body and under her left side.
5. Fold or twist the bottom of the blanket loosely and tuck it under one side of the baby.
6. Make sure her hips can move and that the blanket is not too tight. "You want to be able to get at least two or three fingers between the baby's chest and the swaddle," Dr. Moon explains.

Swaddling in Child Care

Some child care centers may have a policy against swaddling infants in their care. This is because of the increased risks of SIDS or suffocation if the baby rolls over while swaddled, in addition to the other risks of overheating and hip dysplasia.

"We recommend infants wait to enter a child care center until they are about three months old, and by then swaddling should have been phased out because the babies are more active and rolling," said Danette Glassy, MD, FAAP, chair of the AAP Section on Early Education and Child Care and the AAP representative on a panel that wrote guidelines for child care providers.

The guidelines, *Caring for Our Children, National Health and Safety Performance Standards*, which are jointly published by the National Resource Center for Health and Safety in Child Care and Early Education, the AAP and the American Public Health Association, do not ban swaddling in child care centers, but they say swaddling is not necessary or recommended. As a result, some child care centers, and the states where they are located, are implementing more forceful recommendations against swaddling in child care settings.

“Compared to a private home, where one or two people are caring for an infant, a child care center usually has a number of caregivers, who may have variations in their swaddling technique,” Dr. Glassy says. “This raises a concern because studies show babies who are not usually swaddled react differently when swaddled for the first time at this older age.” They may have a harder time waking up, which increases their risk of SIDS.

“The difference in the advice for swaddling at home or the hospital nursery, versus in a child care center, really comes down to the age of the child and the setting,” Dr. Glassy says. “A newborn can be swaddled correctly and placed on his back in his crib at home, and it can help comfort and soothe him to sleep. When the child is older, in a new environment, with a different caregiver, he is learning to roll, and perhaps he hasn’t been swaddled before, swaddling becomes more challenging and risky.”

Last Updated: 1/12/2017

Car Safety Seats Guide

One of the most important jobs you have as a parent is keeping your child safe when your child is riding in a vehicle.

Each year, thousands of young children are killed or injured in car crashes. Proper use of car safety seats helps keep children safe. But, because so many different seats are on the market, many parents find this overwhelming. If you are expectant parents, consider working with a certified passenger safety technician (CPST or CPS technician) , before your baby is born, to ensure a safe ride home from the hospital. (See *If You Need Installation Help*.)

The type of seat your child needs depends on several things, including your child's age, size, and developmental needs. Here is more information from the American Academy of Pediatrics (AAP) about choosing the most appropriate car safety seat for your child. (See *Car Safety Seats Product Information* for a list of seats and manufacturer websites.)

> **NOTE:** The "Types of Car Safety Seats at a Glance" chart is a quick guide on where to start your search. It's important to continue your research to learn about each seat you use.

Installation Information—Seat Belts and LATCH

Car safety seats may be installed with either the vehicle's seat belt or its LATCH (lower anchors and tethers for children) system. LATCH is an attachment system for car safety seats. Lower anchors can be used instead of the seat belt to install the seat, and many parents find them easier to use in some cars. The top tether should always be used with a forward-facing seat, whether you use the seat belt or lower anchors to secure it. The seat belt and LATCH systems are equally safe, so caregivers should use one or the other, whichever works best for them, their car safety seat, and their vehicle. In general, caregivers should use only 1 of the 2 options, unless the car safety seat and vehicle manufacturers say it is OK to use both systems at the same time.

Vehicles with the LATCH system have lower anchors located in the back seat, where the seat cushions meet. Tether anchors are located behind the seat, either on the panel behind the seat (in sedans) or on the back of the seat, ceiling, or floor (in most minivans, SUVs, hatchbacks, and pickup trucks). All forward-facing car safety seats have tethers or tether connectors that fasten to these anchors. Nearly all passenger vehicles and all car safety seats made on or after September 1, 2002, are equipped to use LATCH. See vehicle owner's manual for highest weight of child allowed to use top tether.

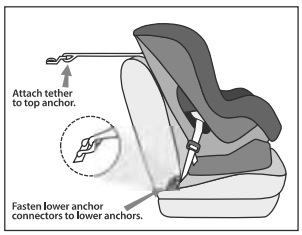


Figure 1. Car safety seat with LATCH (lower anchors and tethers for children).

All lower anchors are rated for a maximum weight of 65 pounds (total weight includes car safety seat and child). Parents should check the car safety seat manufacturer's recommendations for maximum weight a child can be to use lower anchors. New car safety seats have the maximum weight printed on their label.

> **NOTE: Seat belts**—If you install a car safety seat by using your vehicle's seat belt, you must make sure the seat belt locks to hold the seat tightly. In most newer cars, you can lock the seat belt by pulling it all the way out and then allowing it to retract to keep the seat belt tight around the car safety seat. In addition, many car safety seats have built-in lock-offs so you can lock the belt without having to lock the seat belt separately as well. Refer to the vehicle owner's manual for details about how your seat belt locks.
>
> **Middle of the back seat**—The safest place to ride for all children younger than 13 years is the back seat. If possible, it may be best for the child to ride in the middle of the back seat. However, it is sometimes difficult to install a car safety seat tightly in the middle if the vehicle seat is narrow or uneven. Also, many vehicles do not have lower anchors for the middle seating position. It is safest to put the car safety seat in a position where you can install it tightly with either the lower anchor system or the seat belt; in some cases, this position may be on either side of the back seat rather than in the middle. A child passenger safety technician (CPST or CPS technician) can help you decide which place is best to install your child's car safety seat in your vehicle.

Infants and Toddlers—Rear-Facing Seats

The AAP recommends that all infants ride rear facing starting with their first ride home from the hospital. All infants and toddlers should ride in a rear-facing seat as long as possible until they reach the highest weight or height allowed by their car safety seat manufacturer. Most convertible seats have limits that will allow children to ride rear facing for 2 years or more. When infants outgrow their rear-facing–only seat, a convertible seat installed rear facing is needed. All parents can benefit from getting installation help from a CPST to ensure that their child's seat is properly installed. (See *If You Need Installation Help*.)

Types of Rear-Facing Seats

Three types of rear-facing seats are available: rear-facing–only, convertible, and all-in-one. 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 or all-in-one seat.

1. Rear-facing–only seats

- Are used for infants up to 22 to 35 pounds, depending on the model.
- Are small and have carrying handles.
- Usually come with a base that can be left in the car. The seat clicks into and out of the base so you don't have to install the seat each time you use it. Parents can buy more than one base for additional vehicles.
- Should be used only for a child's travel (not sleeping, feeding, or any other use outside the vehicle).

Figure 2. Rear-facing–only car safety seat.

2. Convertible seats (used rear facing)

- Can be used rear facing and, later, "converted" to forward facing for older children when they outgrow either the weight limit or the length limit for rear facing. This means the seat can be used longer by your child. Convertible seats are bulkier than infant seats, however, and they do not come with carrying handles or separate bases and are designed to stay in the car.

Figure 3. Convertible car safety seat used rear facing.

Types of Car Safety Seats at a Glance		
Age-group	**Type of Seat**	**General Guidelines**
Infants and toddlers	Rear-facing–only Rear-facing convertible	All infants and toddlers should ride in a rear-facing seat until they reach the highest weight or height allowed by their car safety seat manufacturer. Most convertible seats have limits that will allow children to ride rear facing for 2 years or more.
Toddlers and preschoolers	Forward-facing convertible Forward-facing with harness	Children who have outgrown the rear-facing weight or height limit for their convertible seat should use a forward-facing seat with a harness for as long as possible, up to the highest weight or height allowed by their car safety seat manufacturer. Many seats can accommodate children up to 65 pounds or more.
School-aged children	Booster	All children whose weight or height exceeds the forward-facing limit for their car safety 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 8 to 12 years of age. All children younger than 13 years should ride in the back seat.
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 the best protection. All children younger than 13 years should ride in the back seat.

- Many have higher limits in rear-facing weight (up to 40–50 pounds) and height than those of rear-facing–only seats, a feature that makes convertible seats ideal for bigger babies and toddlers.
- Have a 5-point harness that attaches at the shoulders, at the hips, and between the legs.
- Should be used only for a child's travel (not sleeping, feeding, or any other use outside the vehicle).

3. All-in-one 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 as your child grows.
- Are often bigger in size, so it is important to check that they fit in the vehicle while they are rear facing.
- Do not have the convenience of a carrying handle or separate base; however, they may have higher limits in rear-facing weight (up to 40–50 pounds) and height than those of rear-facing–only seats, a feature that makes all-in-one seats ideal for bigger babies and toddlers.

Installation Tips for Rear-Facing Seats

Always read the vehicle owner's manual and the car safety seat manual before installing the seat.

When using a rear-facing seat, keep the following tips in mind:

- Place the harnesses in your rear-facing seat in slots that are at or below your child's shoulders.
- Ensure that the harness is snug (you cannot pinch any slack between your fingers when testing the harness straps over the child's shoulders) and that the chest clip is placed at the center of the chest, even with your child's armpits.
- Make sure the car safety seat is installed tightly in the vehicle with either lower anchors or a locked seat belt. Many car safety seats have an integrated lock-off to keep the seat belt locked. If your seat has one, follow the manufacturer's recommendations on how to use it. If you can move the seat at the belt path more than an inch side to side or front to back, it's not tight enough.
- Never place a rear-facing seat in the front seat of a vehicle that has an active front passenger airbag. If the airbag inflates, it will hit the back of the car safety seat, right against your child's head, and could cause serious injury or death.
- If you are using a convertible or all-in-one seat in the rear-facing position, make sure the seat belt or lower anchor webbing is routed through the correct belt path. Check the instructions that came with the car safety seat to be sure.
- Make sure the seat is at the correct angle so your child's head does not flop forward. Check the instructions to find out the correct angle for your seat and how to adjust the angle if needed. All rear-facing seats have built-in recline indicators.
- Check the car safety seat instructions and vehicle owner's manual about whether the car safety seat may contact the back of the vehicle seat in front of it.
- Still having trouble? Check with a certified CPST in your area who can help. See *If You Need Installation Help* for information on how to locate a CPST.

Common Questions

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

A: This is a very common concern of parents, but it should cause them no worry. Children are very flexible and can always easily find a comfortable position in a rear-facing seat. Injuries to the legs are very rare for children facing the rear.

Q: What do I do if my child slouches down or to the side in the car safety seat?

A: You can try placing a tightly rolled receiving blanket on both sides of your child. Many manufacturers allow the use of a tightly rolled small diaper or cloth between the crotch strap and your child, if necessary, to prevent slouching. Do not place padding under or behind your child or use any sort of car safety seat insert unless it came with the seat or was made by the manufacturer for use with that specific seat.

Figure 4. Car safety seat with a small cloth between the crotch strap and infant; chest clip positioned at the center of the chest, even with the infant's armpits; and tightly rolled receiving blankets on both sides of the infant.

Q: Why should I dress my child in thinner layers of clothing before strapping him into a car safety seat?

A: Bulky clothing, including winter coats and snowsuits, can compress in a crash and leave the straps too loose to restrain your child, leading to increased risk of injury. Ideally, dress your baby in thinner layers and wrap a coat or blanket around your baby over the buckled harness straps if needed.

Q: Do preemies need a special car safety seat?

A: A car safety seat should be approved for a baby's weight. Very small babies who can sit safely in a semi-reclined position usually fit better in rear-facing–only seats. Babies born preterm should be screened while still in the hospital to make sure they can sit safely in a semi-reclined position. Babies who need to lie flat during travel may be able to ride in a car bed that meets Federal Motor Vehicle Safety Standard 213. They should be screened again while in the hospital to make sure they can lie safely in the car bed.

Toddlers and Preschoolers—Forward-Facing Seats

Always read the vehicle owner's manual and the car safety seat manual before installing the seat.

Any child who has outgrown the rear-facing weight or height limit for her convertible seat should use a forward-facing seat with a harness for as long as possible, up to the highest weight or height allowed by her car safety seat 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 a seat before reaching 4 years of age, consider using a seat with a harness approved for higher weights and heights.

Types of Forward-Facing Car Safety Seat Restraints

Four types of car safety seat restraints can be used forward facing.

1. **Convertible seats**—Seats can "convert" from rear facing to forward facing. These include all-in-one seats.
2. **Combination seats with harness**—Seats can be used forward facing with a harness for children who weigh up to 40 to 65 pounds (depending on the model) or without the harness as a booster (up to 100–120 pounds, depending on the model).
3. **Integrated seats**—Some vehicles come with built-in forward-facing seats. Weight and height limits vary. Do not use a built-in seat until your child has reached the highest weight or height allowed for your rear-facing convertible car safety seat. Read your vehicle owner's manual for details about how to use these seats.

Figure 5. Forward-facing car safety seat with a harness.

4. **Travel vests**—Vests can be worn by children 22 to 168 pounds and can be an option to traditional forward-facing seats. They are useful for when a vehicle has lap-only seat belts in the rear, for children with certain special needs, or for children whose weight has exceeded that allowed by car safety seats. These vests usually require use of a top tether.

Installation Tips for Forward-Facing Seats

Always read the vehicle owner's manual and the car safety seat manual before installing the seat.

It is important that the car safety seat is installed tightly in the vehicle and that the harness fits your child snugly. To switch a convertible or all-in-one seat from rear facing to forward facing,

- Move the harness shoulder straps to the slots or position that is at or just above your child's shoulders. Check the instructions that came with the seat to be sure you are positioning the shoulder straps correctly.
- You may have to adjust the recline angle of the seat so that it sits more upright in your vehicle. Check the instructions to be sure.
- If using a seat belt, make sure it runs through the forward-facing belt path (be sure to follow car safety seat instructions) and that the seat belt is locked and tightened. Many car safety seats have an integrated lock-off to keep the seat belt locked. If your seat has one, follow the manufacturer's recommendations on how to use it.
- If using the lower anchors, make sure that the weight of your child plus the weight of the seat does not exceed 65 pounds. Most seats now state in the manual and on the stickers on the side the maximum child weight to use the anchors. If the child weighs too much, caregivers must use the seat belt to install.
- Always use the tether when you can. A tether is a strap that is attached to the top part of a car safety seat and holds the seat tightly by connecting to an anchor point in your vehicle (often on the seat back or rear shelf; see your vehicle owner's manual to find where tether anchors are in your vehicle). Tethers give important extra protection by keeping the car safety seat and your child's head from moving too far forward in a crash or sudden stop. All new cars, minivans, and light trucks are required to have tether anchors as of September 2000. Forward-facing seats come with tether straps. A tether should always be used as long as your child has not reached the top weight limit for the tether anchor. Check the car safety seat instructions and vehicle owner's manual for information about the top weight limit and locations of tether anchors.

Common Question

Q: What if I drive more children than those who can be buckled safely in the back seat?

A: It's best to avoid this, especially if your vehicle has airbags in the front seat. All children younger than 13 years should ride in the back seat. If absolutely necessary, a child in a forward-facing seat with a harness may be the best choice to ride in front. Just be sure the vehicle seat is moved as far back away from the dashboard (and airbag) as possible.

School-aged Children—Booster Seats

Booster seats are for older children who have outgrown their forward-facing seats. All children whose weight or height exceeds the forward-facing limit for their car safety 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 8 to 12 years of age. Most children will not fit in most vehicle seat belts without a booster until 10 to 12 years of age. All children younger than 13 years should ride in the back seat. Instructions that come with your car safety seat will tell you the height and weight limits for the seat. As a general guideline, a child has outgrown a forward-facing seat when any of the following situations is true:

Figure 6. Belt-positioning booster seat.

- He reaches the top weight or height allowed for his seat with a harness. (These limits are listed on the seat and in the instruction manual.)
- His shoulders are above the top harness slots.
- The tops of his ears have reached the top of the seat.

Types of Booster Seats

High-back and backless are 2 standard types of booster seats. They do not come with a harness but are used with lap and shoulder seat belts in your vehicle, the same way an adult rides. They are designed to raise a child up so that lap and shoulder seat belts fit properly over the strongest parts of the child's body.

Most booster seats are not secured to the vehicle seat with the seat belt or lower anchors and tether but simply rest on the vehicle seat and are held in place once the seat belt is fastened over a child. However, some models of booster seats can be secured to the vehicle seat and kept in place by using the lower anchors and tether along with lap and shoulder belts. (Currently, only a few vehicle manufacturers offer integrated booster seats.)

Installation Tips for Booster Seats

When using a booster seat, always read the vehicle owner's manual and the car safety seat manual before installing the seat. Booster seats often have a plastic clip or guide to correctly position vehicle lap and shoulder belts. See the booster seat instruction manual for directions on how to use the clip or guide.

Booster seats must be used with lap and shoulder belts. When using a booster seat, make sure

- The lap belt lies low and snug across your child's upper thighs.
- The shoulder belt crosses the middle of your child's chest and shoulder and is off the neck.

If your booster seat has lower anchors or tether attachments, check its manual for installation instructions.

Common Questions

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

A: Lap belts work fine with rear-facing–only, convertible, and forward-facing seats that have a harness but can never be used with a booster seat. If your car has only lap belts, use a forward-facing seat that has a harness and higher weight limits. You could also

- Check to see if shoulder belts can be installed in your vehicle.
- Use a travel vest (check the manufacturer's instructions about the use of lap belts only and about the use of lap and shoulder belts).
- Consider buying another car with lap and shoulder belts in the back seat.

Figure 7. Lap and shoulder seat belts.

Q: What is the difference between high-back boosters and backless boosters?

A: Both types of boosters are designed to raise your child so seat belts fit properly, and both will reduce your child's risk of injury in a crash. High-back boosters should be used in vehicles without headrests or with low seat backs. Many seats that look like high-back boosters are actually combination seats. They come with harnesses that can be used for smaller children and, later, 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 headrests and high seat backs.

Older Children—Seat Belts

Seat belts are made for adults. Children should stay in a booster seat until adult seat belts fit correctly, typically when children reach about 4 feet 9 inches in height and are 8 to 12 years of age. Most children will not fit in a seat belt alone until 10 to 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 the best protection. All children younger than 13 years should ride in the back seat.

Using a Seat Belt

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 her knees bent over the edge of the seat without slouching and can comfortably stay in this position 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 her arm or behind her back. This leaves the upper body unprotected and adds extra slack to 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 safety seats or seat belts.

Common Question

Q: I've seen products that say they can help make the seat belt fit better. Should we get one of these?

A: No, these products are unapproved and should not be used. They may actually interfere with proper seat belt fit by causing the lap belt to ride too high on the stomach or making the shoulder belt too loose. They can even damage the seat belt. This rule applies to car safety seats too; do not use extra products unless they came with the seat or are specifically approved by the seat manufacturer. These products are not covered by any federal safety standards, and the AAP does not recommend they be used. As long as children are riding in the correct restraint for their size, they should not need to use additional devices.

Shopping for Car Safety Seats

When shopping for a car safety seat, keep the following tips in mind:

- No one seat is the "best" or "safest." The best seat is the one that fits your child's size, is correctly installed, fits well in your vehicle, and is used properly every time you drive.
- Don't decide by price alone. A higher price does not mean the seat is safer or easier to use.
- Avoid used seats if you don't know the seat's history. Never use a car safety seat that
  - Is too old. Look on the label for the date the seat was made. Check with the manufacturer to find out how long it recommends using the seat.
  - Has any visible cracks on it.
  - Does not have a label with the date of manufacture and model number. Without these, you cannot check to see if the seat has been recalled.

- Does not come with instructions. You need them to know how to use the seat. Instructions can be found on manufacturer websites or by contacting the manufacturer.
- Is missing parts. Used car safety seats often come without important parts. Check with the manufacturer to make sure you can get the right parts.
- Was recalled. You can find out by calling the manufacturer or contacting the National Highway Traffic Safety Administration (NHTSA) Vehicle Safety Hotline at 888/327-4236. You can also visit the NHTSA website at www.safercar.gov.

- Do not use seats that have been in a moderate or severe crash. Seats that were in a minor crash may still be safe to use, but some car safety seat manufacturers recommend replacing the seat after any crash, even a minor one. The NHTSA considers a crash minor if all the following situations are true:
  - The vehicle could be driven away from the crash.
  - The vehicle door closest to the car safety seat was not damaged.
  - No one in the vehicle was injured.
  - The airbags did not go off.
  - You can't see any damage to the car safety seat.

If you have specific questions about the car safety seat, contact the manufacturer. See *Manufacturer Websites*.

About Airbags

- **Front airbags are installed in all new cars.** When used with seat belts, airbags work well to protect teenagers and adults; however, airbags can be very dangerous to children, particularly to those riding in rear-facing seats and to preschoolers and young school-aged children who are not properly restrained. If your vehicle has a front passenger airbag, infants in rear-facing seats must ride in the back seat. Even in a relatively low-speed crash, the airbag can inflate, strike the car safety seat, and cause serious brain injury and death.

  Vehicles with no back seat or a back seat that is not made for passengers are not the best choice for traveling with small children; however, the airbag can be turned off in some of these vehicles if the front seat is needed for a child passenger. See your vehicle owner's manual for more information.

- **Side airbags are available in most new cars.** Side airbags improve safety for adults in side-impact crashes. Read your vehicle owner's manual for more information about the airbags in your vehicle. Read your car safety seat instructions and the vehicle owner's manual for guidance on placing the seat next to a side airbag.

About Carpooling

If your child is being driven by someone else, make sure

- The car safety seat your child will be using fits properly in the vehicle used for transport.
- The car safety seat being used 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 safety seat correctly.

Child care programs and schools should have written guidelines for transporting children, including

- All drivers must have a valid driver's license. In some states, school bus drivers need to have a special type of license.
- Staff to child ratios for transport should meet or exceed those required for the classroom.
- Every child should be supervised during transport, either by school staff or a parent volunteer, so the driver can focus on driving.
- School staff, teachers, and drivers should know what to do in an emergency, know how to properly use car safety seats and seat belts, and be aware of other safety requirements.

About Car Safety Seats on Airplanes

The Federal Aviation Administration (FAA) and the AAP recommend that children less than 40 pounds be securely fastened in certified child restraints when flying. This will help keep them safe during takeoff and landing or in case of turbulence. Most rear-facing, convertible, and forward-facing seats can be used on airplanes, but booster seats and travel vests cannot.

Read your seat's instruction manual and look for a label on the car safety seat that says, "This restraint is certified for use in motor vehicles and aircraft." You can also consider using a restraint made only for use on airplanes and approved by the FAA. Larger children may use the airplane seat belt or continue to use their car safety seat on the airplane as long as it is labeled for use on aircraft and the child has not exceeded the seat's weight or height limit. Remember that your child will need an appropriate car safety seat to use at your destination. For more information, visit the FAA website at www.faa.gov/travelers/fly_children or the CARES (Airplane Safety Harness for Children) website at www.kidsflysafe.com.

If You Need Installation Help

If you have questions or need help with installing your car safety seat, find a certified child passenger safety technician (CPST or CPS technician). Lists of certified CPSTs and child seat–fitting stations are available on the following websites:

National Child Passenger Safety Certification
https://cert.safekids.org (Click on "Find a Tech" or call 877/366-8154.)

Includes list of CPSTs fluent in Spanish and other languages or with extra training in transportation of children with special needs.

NHTSA Parents and Caregivers
www.safercar.gov/parents/index.htm

Important Reminders

1. **Be a good role model.** Make sure you always wear your seat belt. This will help your child form a lifelong habit of buckling up.
2. **Make sure that everyone who transports your child uses the correct car safety seat or seat belt on every trip, every time.** Being consistent with car safety seat use is good parenting, reduces fussing and complaints, and is safest for your child.
3. **Never leave your child alone in or around cars, and lock your vehicle when it is not in use.** Any of the following situations can happen when a child is left alone in or around a vehicle. A child can
   - Die of heatstroke because temperatures can reach deadly levels in minutes.
   - Be strangled by power windows, retracting seat belts, sunroofs, or accessories.
   - Knock the vehicle into gear, setting it into motion.
   - Be backed over when the vehicle backs up.
   - Become trapped in the trunk of the vehicle.

4. **Always read and follow the manufacturer's instructions for your car safety seat.** If you do not have those, write or call the company's customer service department. Staff will ask you for the model number, name of seat, and date of manufacture. The manufacturer's address and phone number are on a label on the seat. Also, be sure to follow the instructions in your vehicle owner's manual about using car safety seats. Some manufacturers' instructions may be available on their websites.
5. **Remember to fill out and mail in the registration card that comes with the car safety seat.** You can also register your seat on the manufacturer's website. It will be important in case the seat is recalled.
6. **Follow manufacturer directions for cleaning car seats.** Cleaning but not disinfecting is usually permitted because disinfectant products may decrease the protection provided by the seat and harnesses.

Figure 1 adapted from US Department of Transportation, National Highway Traffic Safety Administration (NHTSA). *LATCH Makes Child Safety Seat Installation as Easy as 1-2-3*. Washington, DC: NHTSA; 2011. DOT HS publication 809 489.

Figures 2, 3, 5, 6, and 7 by Anthony Alex LeTourneau.

Figure 4 from Bull MJ, Engle WA; American Academy of Pediatrics Committee on Injury, Violence, and Poison Prevention and Committee on Fetus and Newborn. Safe transportation of preterm and low birth weight infants at hospital discharge.Pediatrics. 2009;123(5):1424–1429.

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Air Bag Safety

An air bag can save your life. However, air bags and young children are a dangerous combination.

Front airbags are installed in all new cars. When used with seat belts, airbags work well to protect teenagers and adults; however, airbags can be very dangerous to children, particularly to those riding in rear-facing seats and to preschoolers and young school-aged children who are not properly restrained.

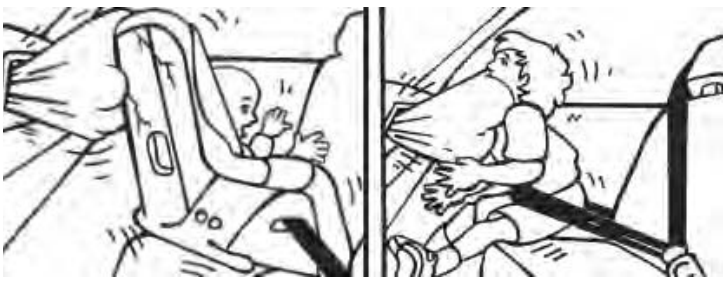
If your vehicle has a front passenger airbag, infants in rear-facing seats must ride in the back seat. Even in a relatively low-speed crash, the airbag can inflate, strike the car seat, and cause serious brain injury and death.

Vehicles with no back seat or a back seat that is not made for passengers are not the best choice for traveling with small children; however, the airbag can be turned off in some of these vehicles if the front seat is needed for a child passenger. See your vehicle owner's manual for more information.

Side airbags are available in most new cars. Side airbags improve safety for adults in side-impact crashes. Read your vehicle owner's manual for more information about the airbags in your vehicle. Read your car seat instructions and the vehicle owner's manual for guidance on placing the seat next to a side airbag.

The following information will help keep you and your children safe:

- The safest place for all infants and children younger than 13 years to ride is in the back seat.
- All children should be properly secured in car seats, belt-positioning booster seats, or the seat belts correct for their size.
    - All infants and toddlers should ride in a rear-facing car seat as long as possible or until they reach the highest weight or height allowed by their car safety seat's manufacturer.
    - 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 the car seat's manufacturer.
    - All children whose weight or height is above the forward-facing limit for their car seat should use a belt-positioning booster until the seat belts fit properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age.
    - When children are old enough and large enough to use seat belt alone, they should always use lap and shoulder seat belts for optimal protection.



What parents can do:

- Eliminate potential risks of air bags to children by buckling them in the back seat for every ride.
- Plan ahead so that you do not have to drive with more children than can be safely restrained in the back seat.
- For most families, installation of air bag on/off switches is not necessary. Air bags that are turned off provide no protection to older children, teens, parents, or other adults riding in the front seat.
- Air bag on/off switches should only be used if your child has special health care needs for which your pediatrician recommends constant observation during travel and no other adult is available to ride in the back seat with your child.
- If no other arrangement is possible and an older child must ride in the front seat, move the vehicle seat back as far as it can go, away from the air bag. Be sure the child is restrained properly. Keep in mind that your child may still be at risk for injuries from the air bag. The back seat is the safest place for children to ride.

Last Updated: 2/24/2020
Source: Adapted from Air Bag Safety (Copyright 2011)

Bathing Your Baby

Bathing your baby is an experience many parents treasure. It's a great time to bond, distraction-free, as your tiny new family member enjoys the sensation of warm water on their skin. Yet this common parenting ritual often comes with questions, and sometimes anxiety, about when and how to do it well.

Here are some frequently asked questions from parents about topics related to baby bath timing, frequency, safety, and more.

When should newborns get their first bath?
The timing of your baby's very first bath has changed over the last few years. While most institutions used to bathe babies within an hour or two of birth, many are changing their policies.

The World Health Organization (WHO) recommends delaying baby's first bath until 24 hours after birth—or waiting at least 6 hours if a full day isn't possible for cultural reasons.

Why wait?
Here are some reasons why it is now recommended to delay baby's first bath:

- **Body temperature and blood sugar: Babies who get baths right away may be more likely to become cold and develop hypothermia. The minor stress of an early bath can also make some babies more likely to have a drop in blood sugar (hypoglycemia).**

- **Bonding and breastfeeding: Taking the baby away for a bath too soon can interrupt skin-to-skin care, mother-child bonding, and early breastfeeding success. One study showed a 166% increase in hospital breastfeeding success after implementing a 12-hour delay in baby's first bath compared to those bathed within the first couple hours.**

- **Dry skin: Vernix, a waxy white substance that coats a baby's skin before birth, acts as a natural moisturizer and may have anti-bacterial properties. Learn more about vernix here. According to the American Academy of Pediatrics (AAP), it's best to leave vernix on a newborns' skin for a while to help prevent their delicate skin from drying out. This is especially important for preemies, as their skin is highly prone to injury.**

Note: Babies of mothers with HIV or the Hepatitis viruses will still be bathed after the initial breastfeed in order to decrease risk to hospital staff and family members.

How often do babies need a bath once they are home?
Newborns don't need a bath every day. They rarely sweat or get dirty enough to need a full bath that often.

Three baths per week during baby's first year may be enough. Bathing more frequently can dry out your baby's skin.

Can my baby have a bath before the umbilical cord falls off?
Only give your newborn sponge baths until the stump of the umbilical cord falls off, which usually happens by about one or two weeks of age. If it remains beyond that time, there may be other issues at play. See the baby's doctor if the cord has not dried up and fallen off by the time the baby is two months old. Learn more here.

How to give a sponge bath
A sponge bath is like a regular bath, except you don't put your baby in the water.

Baby sponge bath safety tips:

- **Get supplies ready before you begin. Have a basin of water, a damp washcloth rinsed in soap-free water, a dry towel, and anything else you might need within reach before you begin.**

- **Lay baby on a flat surface that is comfortable for both of you—a changing table, bed, floor, or counter next to the sink will do. Pad hard surfaces with a blanket or fluffy towel. If your baby is on a surface above the floor, always use a safety strap or keep one hand on her to prevent falls.**

- **Start washing the face first. Use the dampened cloth to wash her face, being careful not to get water into her eyes or mouth. Then, dip it in the basin of water before washing the rest of her body and, finally, the diaper area.**

- **Keep baby warm. During the sponge bath, wrap your baby in a dry towel and uncover only the parts of her body you are actively washing. Pay special attention to creases under the arms, behind the ears, around the neck, and, especially with a girl, in the genital area.**

When is my baby ready for a regular bath?
Once the umbilical area is healed, you can try placing your baby directly in the water. His first baths should be as gentle and brief as possible. He may protest a little. (If this happens go back to sponge baths for a week or two, then try the bath again). Babies usually make it clear when they're ready.

Baby bathtub safety tips:

- **Use an infant tub or sink. The US Consumer Product Safety Commission recommends a hard plastic baby bathtub that has a sloped, textured surface or sling that keeps your baby from sliding. Only use an infant bath tub manufactured on or after October 2, 2017 so it meets current safety standards. Some parents find it easiest to bathe a newborn in a bathinette, sink, or plastic tub lined with a clean towel. Yes, a sink! Sometimes easiest is best; just be careful. Sinks are slippery and have all sorts of things sticking out like faucets and handles.**

    - **Avoid using bath seats. These seats provide support so a child can sit upright in an adult bathtub. Unfortunately, they can easily tip over. A child can fall into the bathwater and drown.**

- **Use touch supervision. Have a towel and other bath supplies within reach so you can keep a hand on your baby at all times. If you've forgotten something or need to answer the phone or door during the bath, you must take the baby with you.**
    - **Start practicing infant water safety now: Never leave a baby alone in the bath, even for an instant. Most child drownings inside the home occur in bathtubs, and more than half of bathtub deaths involve children under 1 year of age.**
- **Check the water temperature. Fill the basin with 2 inches of water that feels warm—not hot—to the inside of your wrist or elbow. If you're filling the basin from the tap, turn the cold water on first (and off last) to avoid scalding yourself or your child. The American Academy of Pediatrics (AAP) recommends that the hottest temperature at the faucet should be no more than 120 degrees Fahrenheit to help avoid burns. In many cases you can adjust your water heater setting to not go above this temperature. Tap water that's too hot can quickly cause burns serious enough to require a hospital visit or even surgery. In fact, hot water scalds are the top cause of burns among babies and young children.**
- **Keep baby warm. Once you've undressed your baby, place her in the water immediately so she doesn't get chilled. Use one of your hands to support her head and the other to guide her in, feet first. Talk to her encouragingly, and gently lower the rest of her body until she's in the tub. Most of her body and face should be well above the water level for safety, so you'll need to pour warm water over her body frequently to keep her warm.**
- **Use soap sparingly. Soaps can dry out your baby's skin. If a cleanser is needed for heavily soiled areas, use only mild, neutral-pH soaps without additives. Rinse soap from the skin right away. Wash baby's hair two or three times a week using a mild shampoo or body wash.**
    - **You may see some scaly patches on your baby's scalp called cradle cap—a harmless condition that appears in many babies. You can loosen the scales with a soft-bristled brush while shampooing in the bathtub, but it's also okay to leave it alone if it doesn't bother you. It's unlikely to bother your baby, and she will outgrow it.**
- **Clean gently. Use a soft cloth to wash your baby's face and hair, being careful not to scrub or tug the skin. Massage her entire scalp gently, including the area over her fontanelles (soft spots). When you rinse shampoo from her head, cup your hand across her forehead so the suds run toward the sides, not into her eyes. If some suds do get into her eyes, use the wet washcloth to wipe them with plain, lukewarm water. Wash the rest of her body from the top down.**
- **Have fun in the tub. If your baby enjoys her bath, give her some extra time to splash and play in the water. The more fun your child has in the bath, the less she'll be afraid of the water. Bathing should be a very relaxing and soothing experience, so don't rush unless she's unhappy.**

    - **Young infants don't really need bath toys, since just being in the water is usually exciting enough. Once a baby is old enough for the bathtub, however, toys become key. Containers, floating toys, even waterproof books make wonderful distractions as you cleanse your baby.**

- **Get out and dry off. When bath time is finished, promptly wrap a towel around your baby's head and body to help her stay warm while she is still wet. Bathing a baby of any age is wet work, so you may want to wear a terry-cloth apron or hang a towel over your shoulder to keep yourself dry. Gently pat baby dry and apply a small amount of fragrance-free, hypoallergenic moisturizing lotion right after a bath to help prevent dry skin or eczema.**

Remember…
Knowing the basics can make bathing your infant a breeze. Just make sure your baby stays comfortable and safe during bath time—and don't forget to soak up all the special moments that come with it!

Additional Information:

- Infant Water Safety: Protect Your New Baby from Drowning
- 5 Bathroom Safety Tips for Infants & Young Children
- Baby Birthmarks & Rashes

Last Updated: 3/3/2020
Source: By: Dipesh Navsaria, MPH, MSLIS, MD, FAAP; American Academy of Pediatrics (Copyright © 2019)

Baby Sunburn Prevention

Why is a baby at special risk from sunburn?

A baby's skin is more delicate and thinner than an adult's and burns and irritates more easily. Even dark-skinned babies may be sunburned. Babies cannot tell you if they are too hot or beginning to burn and cannot get out of the sun without an adult's help. Babies also need an adult to dress them properly and to apply sunscreen.

Prevention Tips

Learn how to stop sunburn before it happens and keep your baby happy, safe, and smiling:

- Babies younger than 6 months should be kept out of direct and indirect sunlight because of the risk of heat stroke. Particularly, avoid having a baby out between 10 a.m. and 2 p.m. when the sun's rays are strongest.
- Keep babies in the shade as much as possible. For example, they should be moved under a tree, beach umbrella, or stroller canopy. However, it is important to note that although on reflective surfaces, an umbrella or canopy may reduce UVR exposure by only 50%.
- Dress babies in lightweight cotton clothing with long sleeves and long pants and a sun hat with a wide brim.
- Sunscreen may be applied to babies younger than 6 months to small areas of skin uncovered by clothing and hats. Remember to cover all exposed areas of a baby's skin, including the face, back of the hands, back of the neck, tips of the ears, and tops of the feet.
- Apply the protection 15 to 30 minutes before going out. Keep in mind that no sunscreens are truly waterproof, and thus they need to be reapplied every one and a half to two hours, particularly if a baby goes into the water. Consult the instructions on the bottle.

Last Updated 11/21/2015

Getting Your Baby to Sleep

What's the best way to get my child to go to sleep?

Babies

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.

Here are some suggestions that may help your baby (and you) sleep better at night.

1. **Keep your baby calm and quiet when you feed or change her during the night**. Try not to stimulate or wake her too much.
2. **Make daytime playtime**. Talking and playing with your baby during the day will help lengthen her awake times. This will help her sleep for longer periods during the night.
3. **Put your baby to bed when drowsy but still awake**. This will help your baby learn to fall asleep on her own in her own bed. Holding or rocking her until she is completely asleep may make it hard for her to go back to sleep if she wakes up during the night.
4. **Wait a few minutes before responding to your child's fussing.** See if she can fall back to sleep on her own. If she continues to cry, check on her, but don't turn on the light, play with her, or pick her up. If she gets frantic or is unable to settle herself, consider what else might be bothering her. She may be hungry, wet or soiled, feverish, or otherwise not feelingwell.

Toddlers and preschoolers

Many parents find their toddler's bedtime to be the hardest part of the day. Children this age often resist going to sleep, especially if they have older siblings who are still awake.

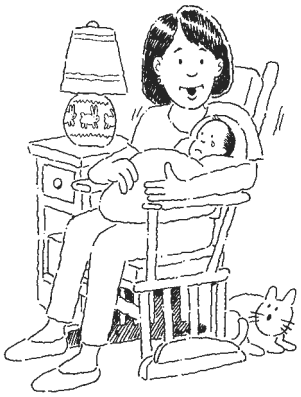
Use the following tips to help your toddler develop good sleep habits:

1. **Set up a quiet routine before bedtime** to help your child understand that it will soon be time to go to sleep. Use this time to read him a story, listen to quiet music, or give him a bath. It may be tempting to play with your child before bed. However, active play may make your child too excited to sleep.
2. **Be consistent**. Make bedtime the same time every night. This helps your child know what to expect and helps him establish healthy sleep patterns.
3. **Allow your child to take a favorite thing to bed each night**. It's OK to let your child sleep with a teddy bear, special blanket, or some other favorite toy. These often help children fall asleep— especially if they wake up during the night. Make sure the object is safe. Look for ribbons, buttons, or other parts that may be choking hazards. Stuffing or pellets inside stuffed toys can also be dangerous.

4. **Make sure your child is comfortable**. He may like to have a drink of water, a light left on, or the door left slightly open. Try to handle your child's needs before bedtime so that he doesn't use them to avoid going to sleep.
5. **Do not let your child sleep in the same bed with you**. This can make it harder for him to fall asleep when he is alone.
6. **Do not return to your child's room every time he complains or calls out**. Instead, try the following:
   - Wait several seconds before answering and make your response time longer each time he calls. This will give him a chance to fall asleep on his own.
   - Reassure your child that you are there. If you need to go into the room, do not turn on the light, play with him, or stay too long.
   - Move farther from your child's bed every time you go in, until you can reassure him verbally without entering his room.
   - Remind him each time he calls that it's time to go to sleep.
7. **Give it time**. Helping your child develop good sleep habits can be a challenge, and it is normal to get upset when a child keeps you awake at night. Try to be understanding. A negative response by a parent can sometimes make a sleep problem worse.

Last Updated: 7/16/2018

Crying and Your Baby:
How to Calm a Fussy or Colicky Baby



Babies cry for different reasons. Crying is one way babies try to tell us what they need. They may be hungry, have a soiled diaper, or just want a little attention. (See checklist at the end of this brochure.) If a crying baby cannot be comforted, the cause may be colic. Read on for more information from the American Academy of Pediatrics about colic and ways to calm a crying baby.

What is colic?

Colic is a word used to describe healthy babies who cry a lot and are hard to comfort. No one knows for sure what causes colic, but it may be an immaturity of the digestive system. In general, babies with colic will be fussy but continue to gain weight and develop normally. If you are concerned, it is best to check with your child's doctor to make sure there is not another medical cause.

Who gets colic?

About 1 out of every 5 babies develops colic. Each baby is different, but in general

- Colic starts when a baby is 2 to 4 weeks of age and usually peaks around 6 weeks.
- Colic usually starts to get better when babies are cooing and smiling sociably, around 8 weeks.
- Colic usually resolves by 3 to 4 months but can last until 6 months.

How can I tell if my baby has colic?

Here are different ways babies with colic may act.

- Crying is intense, sometimes up to 3 to 5 hours a day. Between crying episodes, babies act normal.
- Crying is often predictable, often at the same time each day. It usually occurs in the late afternoon to evening.
- When crying, babies often pass gas, pull their legs up, or stretch their legs out.

Ways to calm a fussy or colicky baby

Here are ways you can try to comfort a crying baby. It may take a few tries, but with patience and practice you'll find out what works and what doesn't for your baby.

- **Swaddle your baby** in a large, thin blanket (ask your nurse or child's doctor to show you how to do it correctly) to help her feel secure.
- **Hold your baby** in your arms and place her body either on her left side to help digestion or stomach for support. Gently rub her back. If your baby goes to sleep, remember to always lay her down in her crib on her back.
- **Turn on a calming sound.** Sounds that remind babies of being inside the womb may be calming, such as a white noise device, the humming sound of a fan, or the recording of a heartbeat.
- **Walk your baby in a body carrier or rock her.** Calming motions remind babies of movements they felt in the womb.
- **Avoid overfeeding your baby** because this may also make her uncomfortable. Try to wait at least 2 to 2½ hours from the beginning of one feeding to the next.
- **If it is not yet time to feed your baby, offer the pacifier or help your baby find her thumb or finger.** Many babies are calmed by sucking.
- **If food sensitivity is the cause of discomfort, a change in diet may help.**
  - For breastfed babies, moms may try changing their own diet. See if your baby gets less fussy if you cut down on milk products or caffeine. If there is no difference after making the dietary changes, resume your usual diet. Avoiding spicy or gassy foods like onions or cabbage has worked for some moms, but this has not been scientifically proven.
  - For bottle-fed babies, ask your child's doctor if you should try a different formula. This has been shown to be helpful for some babies.
- **Keep a diary of when your baby is awake, asleep, eating, and crying.** Write down how long it takes your baby to eat or if your baby cries the most after eating. Talk with your child's doctor about these behaviors to see if her crying is related to sleeping or eating.

Baby's Daily Log
Date:

Time	Description	Notes

- **Limit each daytime nap to no longer than 3 hours a day.** Keep your baby calm and quiet when you feed or change her during the night by avoiding bright lights and noises, such as the TV.

What your baby may need checklist

Here are some other reasons why your baby may cry and tips on what you can try to meet that need.

If your baby is…

Hungry. Keep track of feeding times and look for early signs of hunger, such as lip-smacking or moving fists to his mouth.

Cold or hot. Dress your baby in about the same layers of clothing that you are wearing to be comfortable.

Wet or soiled. Check the diaper. In the first few months, babies wet and soil their diapers a lot.

Spitting up or vomiting a lot. Some babies have symptoms from gastroesophageal reflux (GER), and the fussiness can be confused with colic. Contact your child's doctor if your baby is fussy after feeding, has excessive spitting or vomiting, and is losing or not gaining weight.

Sick (has a fever or other illness). Check your baby's temperature. If your baby is younger than 2 months and has a fever, call your child's doctor right away.

Overstimulated. See Ways to calm a fussy or colicky baby.

Bored. Quietly sing or hum a song to your baby. Go for a walk.

Parents and caregivers need breaks from crying babies

If you have tried to calm your crying baby but nothing seems to work, you may need to take a moment for yourself. Crying can be tough to handle, especially if you're physically tired and mentally exhausted.

1. Take a deep breath and count to 10.
2. Place your baby in a safe place, such as crib or playpen without blankets and stuffed animals; leave the room; and let your baby cry alone for about 10 to 15 minutes.
3. While your baby is in a safe place, consider some actions that may help calm you down.
   - Listen to music for a few minutes.
   - Call a friend or family member for emotional support.
   - Do simple household chores, such as vacuuming or washing the dishes.
4. If you have not calmed after 10 to 15 minutes, check on your baby but *do not* pick up your baby until you feel you have calmed down.
5. When you have calmed down, go back and pick up your baby. If your baby is still crying, retry soothing measures.
6. Call your child's doctor. There may be a medical reason why your baby is crying.

Try to be patient. Keeping your baby safe is the most important thing you can do. It is normal to feel upset, frustrated, or even angry, but it is important to keep your behavior under control. Remember, **it is never safe to shake, throw, hit, slam, or jerk any child**—and it never solves the problem!

From your doctor

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The American Academy of Pediatrics (AAP) is an organization of 64,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of all infants, children, adolescents, and young adults.

American Academy of Pediatrics
Web site— www.HealthyChildren.org

Choosing Quality Child Care: What's Best for Your Family?

Finding high-quality child care is very important but not always easy. Your choice will play a key role in your child's health and development. Read on for more information from the American Academy of Pediatrics (AAP) about child care options to help you in your search for what's best for your family.

Types of child care

Center-based care, family child care, and in-home care are 3 types of child care.

- **Center-based care** takes place in a location staffed by caregivers. Center-based care has many names—child care center, preschool, nursery school, child development program, or learning center. Center-based care also may have different sponsors, including churches, schools, colleges, universities, hospitals, social service agencies, Head Start, independent owners and businesses, and employers.
- **Family child care** takes place in the caregiver's home. Many family child care providers have young children of their own. They may care for children who are the same age as their own children or for children of different ages.
- **In-home care** takes place in the child's home. The caregiver comes to or lives in the home. For many families, this is very convenient because caregivers often can arrange their schedules to match your needs. Because your child stays at home, he does not have to adjust to a new setting. Your child may also be exposed to fewer illnesses because he will not be with groups of children. He may receive more individual attention, especially if the caregiver's main job is to care for your child. This type of caregiver is not monitored or supervised, and there is no formal licensure or regulation process.

Note for parents of children with special needs: Finding programs and caregivers to meet the needs of children with disabilities or other special needs can be challenging. Your child's doctor can help you and your child's caregiver plan for your child's special needs, development, activities, health, safety, and any problems that come up while you are using child care.

Questions for all caregivers

The right child care option for your family may be based on many factors, including work schedules, budget, and personal preferences. Answers to the following questions may help you in your search.

- **Hours.** What are the hours? What if you are late in picking up your child? How are vacations and holidays scheduled?
- **Fees and services.** What is the cost? How are payments made? Are there other services available in addition to child care? Is there an extra cost?
- **Qualifications and training.** What education, training, and experience does the child care provider(s) have? Is the child care provider certified in CPR?
- **Discipline.** Is the caregiver(s) policy on discipline the same as yours? Center-based care should have a discipline policy.
- **Communication.** How often does the child care provider give feedback about your child? Does the child care provider seem approachable?
- **Transportation.** Are the proper car safety seats, booster seats, and seat belts used? Center-based care should have a transportation policy.
- **References.** Does the caregiver have current references from parents you can contact?

Other questions for center-based care

- **Policies.** The center should have a written policy for each of the following areas: health standards, illness, medication, nutrition, discipline, transportation, media, and outdoor play.
- **Licensing/accreditation.** Is the center licensed or registered with the appropriate local government agencies? Are there any outstanding violations? Is the program currently accredited or in the process of becoming accredited?
- **Health professional.** Is there a qualified health professional, such as a doctor or nurse, for the program? (The national standard recommends that center-based infant-toddler programs should be visited by a health professional at least once a month, and all other child care programs should be visited at least once every 3 months.)
- **Visiting policy.** Can you visit the center before your child is enrolled? If your child is enrolled, can you visit the center anytime it is open? Can you see all the areas that your child will use? Are visitors screened or is their identification checked so that only approved adults can visit the center and pick up children?
- **Qualifications and training.** What type of additional training have the staff had during the past year? Do outside experts provide training? How long have the staff worked at the center? How much experience do they have with children of your child's age?
- **Staffing.** Are there enough trained adults available on a regular basis? What happens if staff are ill or on vacation? Are children supervised by sight and sound at all times, even when they are sleeping? Are children cared for in small groups? Are activities proper for their age group? Is there a daily schedule?

  Do the child-staff ratios and the size of groups of children fall within nationally recognized standards? For example, in a room with 4 children aged 13 to 35 months, there should be 1 trained caregiver. In a room with 5 to 8 children aged 13 to 35 months, there should be 2 trained caregivers. There should be no more than 8 children aged 13 to 35 months in a room. (See chart.)

Age	Maximum Child-Staff Ratio*	Maximum Group Size*
12 months	3:1	6
13–35 months	4:1	8
3-year-olds	7:1	14
4-year-olds	8:1	16
5-year-olds	8:1	16
6- to 8-year-olds	10:1	20
9- to 12-year-olds	12:1	24

*As recommended by the AAP. See *Caring for Our Children* listed in "Resources."

Other questions for family child caregivers

- **Others in the home.** Who lives in or visits the home (children, teens, and adults)? Are they family, what are their backgrounds, and how may they interact with your child?
- **Number of children.** What is the total number of children being cared for? The AAP recommends that a family child care home should not have more than 6 children per adult caregiver, including the caregiver's own children. (Some states allow more children when at least 2 adults are available at all times in larger family child care homes.) The total number of children should be fewer when infants and toddlers are included. No caregiver who works alone should care for more than 2 children younger than 2 years.
- **Staffing.** Does the caregiver plan to leave the home during the day to go to the store or drive children to school? If so, find out what the plan is for who will care for your child during this time. Because there usually is only one adult, backup care in an emergency situation must be nearby. In some areas, caregivers belong to a network of family child care providers who may provide training, shared toys, and backup help.
- **Qualifications and training.** Look for caregivers who are licensed or registered with the state. These caregivers will have unannounced visits by an inspector. Some family child care providers have earned accreditation as well. Does the caregiver continue to receive training?
- **Environment.** Is there an outdoor play area? Is the home free from hazards, such as lead and mold? Are there any pets?

Guidelines for in-home caregivers

When you are interviewing in-home caregivers it is important that your expectations are clear. Your caregiver will need to respect and follow your parenting rules and assigned duties. For example,

- **Your child's schedule.** Include such things as typical mealtimes, hand washing, toilet training, teeth brushing, and nap time.
- **Discipline.** Let your caregiver know what types of discipline you approve of and what rules and limits you have set for your child.
- **Activities.** Discuss reading, playtime, and fun ways to be active inside and outside. Be sure to talk about what types of outings are acceptable for your child. Let your caregiver know how long your child is allowed to watch TV or videos or play computer games or other media. The AAP strongly discourages TV viewing for children 2 years and younger, and encourages interactive play. For older children, the AAP recommends no more than 1 to 2 hours per day of educational, nonviolent programming.
- **Duties.** Write down and review what the caregiver will and will not do in your home. If your caregiver will also have housekeeping duties, stress that your child's needs must come first. Also discuss what you expect the caregiver to do if your child has a minor injury or if there is an emergency.
- **Transportation.** Be sure your caregiver knows how to use the proper car safety seat, booster seat, or seat belt for your child.
- **Communication.** The caregiver should give you a daily report of what occurred. (You may want to arrange for frequent, unannounced visits by a friend or family member who can observe how the caregiver interacts with your child.)

Note: You will need a backup plan for times when the caregiver is sick, needs time off, or goes on vacation. In some areas, child care resource and referral agencies or other community organizations can give you names of temporary in-home caregivers.

Planning for child care costs

Child care can be expensive, so families must budget ahead of time. While the cost may seem high, think about how little the caregiver is actually earning per hour for the responsibility of caring for your child. Be sure to budget for your backup care during those times when your child or caregiver is ill. You may qualify for state subsidies or assistance from your employer. Ask about

- Direct payment through cafeteria plans (a type of flexible benefit plan)
- Dependent-care spending accounts (tax savings)
- Voucher programs
- Employer discounts

High-quality child care is a critical investment for your child. When care is consistent, developmentally sound, and emotionally supportive, there is a positive effect on the child and family. In some areas your local child care resource and referral agency can help you find licensed child care or apply for subsidies. For more information, visit www.naccrra.org or www.childcareaware.org.

Preparing your child

Most infants, up to 7 months of age, adjust well to good child care. Older infants may get upset when left with strangers. They will need extra time and your support to get to know the caregiver and to understand that you will pick them up at the end of the day. Starting new child care is often harder on the parents than it is on the child.

Being prepared makes any new experience easier. You can help your child adjust to a new child care arrangement. Try the following:

- Arrange a visit with in-home caregivers while you are at home or when you need child care for a short time.

A checklist to help rate your choice

"Is This the Right Place for My Child? 38 Research-Based Indicators of High-Quality Child Care" is a checklist put together by Child Care Aware of America (formerly the National Association of Child Care Resource & Referral Agencies [NACCRRA]) that you can use to evaluate child care programs. This checklist is on the Child Care Aware of America Web site at www.naccrra.org/sites/default/files/publications/naccrra_publications/2012/38indicatorschecklist.pdf and available through a link from the American Academy of Pediatrics Healthy Child Care America Web site at www.healthychildcare.org/ResourcesFamilies.html. All of the questions are based on research about what is important to your child's health, safety, and development.

- Visit the center or home with your child before beginning care. Show your child that you like and trust the caregiver.
- Check with the caregiver or center staff about the best time of the month or year for children to begin attending the program.
- Allow your child to carry a reminder of home to child care. A family photograph or small toy can be helpful.
- Talk with your child about child care and the caregiver.
- Read books about child care. (Check with your local library.)

Sudden changes in caregivers may be upsetting to a child. This can happen even if the new caregiver is kind and competent. You may want to arrange a meeting with the new caregiver or ask your child's doctor for advice. Parents need to help caregivers and the child deal with any changes in the child's routine at home or child care.

When your child gets sick

Children sometimes get sick or are injured while in child care. Talk with your child's caregiver in advance so that you both know what to expect and are prepared. Make sure that your caregiver can always reach you. Confirm a plan for emergency care in advance.

Many times, mildly ill children are allowed to stay with their caregiver as long as they can participate in most of the activities and don't require more care than their caregiver can provide. If the child needs extra rest, there must be a place for her to rest and still be observed.

Sometimes children need medicine while they are at child care. Every state and program will have different rules about what is allowed. Prescription and over-the-counter medicines should be labeled with the child's name, dosage, and expiration date. The caregiver should have the parent's written permission to give the medicine, know how to give it safely, and properly record each dose. Depending on the regulations in your state, sometimes a doctor's note or instructions are required.

Resources

The following is a list of early education and child care resources. Check with your child's doctor or local child care resource and referral agency for resources in your community.

Web sites

AAP Healthy Child Care America Early Education and Child Care Initiatives
This AAP site has a useful parent section and links to all the other Web sites listed here.
888/227-5409
www.healthychildcare.org

Child Care Aware of America (formerly National Association of Child Care Resource & Referral Agencies [NACCRRA])
703/341-4100 or 800/424-2246
www.naccrra.org or www.childcareaware.org

National Association for the Education of Young Children (NAEYC)
800/424-2460
www.naeyc.org

National Association for Family Child Care (NAFCC)
801/886-2322
www.nafcc.org

National Resource Center for Health and Safety in Child Care and Early Education (NRC)
800/598-KIDS (800/598-5437)
http://nrckids.org

Books from the American Academy of Pediatrics

Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Early Care and Education Programs

Caring for Your Baby and Young Child: Birth to Age 5

Caring for Your School-Age Child: Ages 5 to 12

Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide

Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide

From your doctor

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

The American Academy of Pediatrics is an organization of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults.

American Academy of Pediatrics
Web site — www.HealthyChildren.org

HOW ARE YOU FEELING NOW?

While many women experience some mild mood change or "the blues" during or after the birth of a child, 1 in 7 women experience more significant symptoms of depression or anxiety. 1 in 10 Dads become depressed during the first year.

PARENTS:

Are you feeling sad or depressed?

Is it difficult for you to enjoy yourself?

Do you feel more irritable or tense?

Do you feel anxious or panicky?

Are you having difficulty bonding with your baby?

Do you feel as if you are "out of control" or "going crazy"?

Are you worried that you might hurt your baby or yourself?

FAMILIES:

Do you worry that something is wrong but don't know how to help?

Do you think that your partner or spouse is having problems coping?

Are you worried that it may never get better?

Any parent can suffer from pregnancy or postpartum mood or anxiety disorders. However, with informed care you can prevent a worsening of symptoms and can fully recover. It is essential to recognize symptoms and reach out as soon as possible so that you can get the help you need and deserve.

THINGS YOU CAN DO

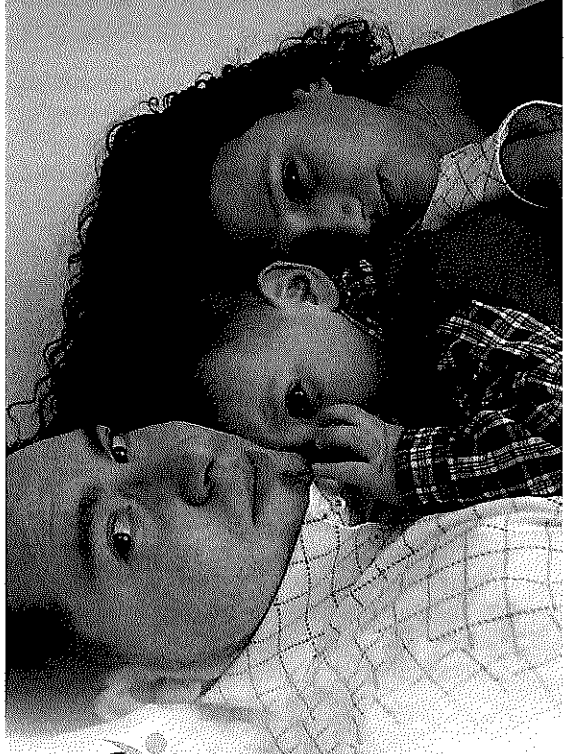
Being a good parent includes taking care of yourself. If you take care of yourself, you will be able to take better care of your baby and your family.

- Talk to a counselor or healthcare provider who has training in perinatal mood and anxiety problems.
- Learn as much as you can about pregnancy and postpartum depression and anxiety.
- Get support from family and friends. Ask for help when you need it.
- Join a support group in your area or online.
- Keep active by walking, stretching or whatever form of exercise helps you to feel better.
- Get enough rest and time for yourself.
- Eat a healthy diet.
- Don't give up! It may take more than one try to get the right help you need.
- Call or email us; we will help you.

@postpartumhelp

www.postpartum.net

Supporting Postpartum Families



PSI POSTPARTUM SUPPORT INTERNATIONAL

Postpartum Support International
Office: (503) 894-9453
Fax: (503) 894-9452
www.postpartum.net
psioffice@postpartum.net

1-800-944-4PPD (4773)

Brochures available in English & Español
Find them at www.postpartum.net/resources

Remember

you are not alone
you are not to blame
with help, you will be well

Call our Warmline
1-800-944-4PPD

Visit us on the web
www.postpartum.net

Postpartum Support International is a worldwide non-profit organization dedicated to helping women and families suffering from perinatal mood and anxiety disorders. PSI was founded in 1987 to increase awareness among public and professional communities about the emotional difficulties that women can experience during and after pregnancy. The organization offers support, reliable information, best practice training, and volunteer coordinators in all 50 U.S. states and more than 35 other countries. Working together with its volunteers, caring professionals, researchers, legislators and others, PSI is committed to eliminating stigma and ensuring that compassionate and quality care is available to all families.

We Can Help
We Offer

PHONE SUPPORT

- Call the PSI Warmline (1-800-944-4PPD) for information and to get connected to resources for help and healing in your own community. Open during business hours Pacific Time, or leave a message any time.
- "Chat with the Expert" phone sessions. You can talk to an expert and get your questions answered in a safe and supportive setting with PSI's weekly chats. Chats for moms are on Wednesdays, and for dads on First Mondays. These conference calls are free and open to everyone. Callers may remain anonymous. Details at www.postpartum.net/resources.

WEBSITE

- Information and Articles about Pregnancy and Postpartum Mood Disorders
- Comprehensive List of Free Support Groups
- Knowledgeable local coordinators who will offer support, information, and resources, and email support
- Guide to Resources on the Web
- Calendar of events in the perinatal mood disorderscommunity
- Latest News and Research
- Member's Section for Access & Networking

PSI NEWSLETTER

- Newsletter with updates on PSI activities
- Best practices, women's stories and legal issues
- Worldwide events and news

TRAINING

- Annual June conference to discuss latest science, treatment approaches, research, and social support systems.
- Standardized certificate training, manuals, and courses for professionals, volunteers, and support groups.
- Online Webinar certificate course in Maternal Mental Health.
- Training and guidance for developing social support groups and networks.

Parents of every culture, age, income level and race can get Perinatal Mood and Anxiety Disorders. Symptoms can appear any time during pregnancy and the first year after childbirth. There are effective and well-researched treatment options to help you recover. Although the term "postpartum depression" is often used, there are actually several overlapping illnesses.

- Pregnancy or Postpartum Depression might include feelings of anger, irritability, guilt, lack of interest in the baby, changes in eating and sleeping, trouble concentrating, thoughts of hopelessness and sometimes thoughts of harming the baby or yourself.
- Pregnancy or Postpartum Anxiety might include extreme worries and fears, including the health and safety of the baby. Some women have panic attacks and might feel shortness of breath, chest pain, dizziness, feeling of losing control, numbness and tingling.
- Pregnancy or Postpartum Obsessive-Compulsive Disorder might include repetitive, upsetting and unwanted thoughts or mental images, and sometimes the need to do certain things over and over to reduce the anxiety caused by those thoughts. These moms find these thoughts very scary and unusual and are very unlikely to ever act on them.
- Postpartum Stress Disorder is often caused by a traumatic or frightening childbirth, symptoms might include flashbacks of the trauma with feelings of anxiety and the need to avoid things related to that event.
- Postpartum Psychosis might include seeing or hearing voices or images others can't, feeling very energetic and unable to sleep, believing things that are not true and distrusting those around you. This rare illness can be dangerous so it is important to seek help immediately.

Penile Adhesions in the *Circumcised* Penis

During the first few years of life, it is common for the head of the penis to stick to the skin on the end of the penis shaft. These are called penile adhesions and are not a serious problem. Usually if left alone, they will self-resolve by 3 years of age. Forcefully pulling back on the adhesions (stuck tissues) can cause pain and bleeding and is *not* recommended.

Why does this happen?
The fat pad above the penis grows a lot during the infant years. This makes the penis appear to shrink as it is swallowed up by the fat pad. This allows the skin of the penis to rub against the head of the penis. Small irritations occur on the skin surface, causing it to stick to the surrounding tissues.

Why does it look like cottage cheese along the edge?
The cells on the surface of the glans and inside the foreskin are discarded normally, like other cells of the body. Routine cleaning can prevent the accumulation of these cells. If these cells accumulate, they form a white cheesy substance called smegma. Adhesions usually do not cause any problems and no treatment is necessary, even if smegma develops. If this happens, you might notice white pearly, cheesy smegma coming out of the edge of the adhesion. This does not require treatment. *If it becomes red and swollen, make an appointment with your doctor.*

How do I prevent this from happening?
As boys build up baby fat, they tend to get a large fat pad at the base of the penis. The penis often hides in the fat pad. You should push down on the fat pad near the base of the penis to expose the penis for cleaning with bathing. If you notice that the skin starts to "stick" to the head of the penis (aka the glans), put petrolatum jelly in the area several times per day to prevent more adhesions.

Once your son is older you can teach him to clean his own penis with normal bathing.

Source: https://pediatricpartnerskc.com/Education/Illnesses-Symptoms/Penile-Adhesions

11/2020

Care of the Uncircumcised Penis

At birth, boys have skin that covers the end of the penis, called the foreskin. One choice you will make for your new baby boy is whether to have him circumcised. Circumcision is a surgical procedure that removes the foreskin, exposing the tip of the penis.

If your son is not circumcised, the following are things you should know and teach your son as he gets older.

How do I clean my baby's foreskin?

In the first few months, clean your baby's penis with soap and warm water. Cotton swabs or antiseptics are not necessary. *Do not pull back the foreskin* if it's still attached.

When will the foreskin retract?

In the first several years your son's foreskin will separate from the tip of the penis. Some foreskins separate soon after birth or even before birth, but this is rare. When it happens is different for every child. It may take a few weeks, months, or years. Once this happens, the foreskin can be pulled back away from the tip of the penis. This is called *foreskin retraction.*

Most boys will be able to retract their foreskins by the time they are 5 years old, yet others will not be able to until the teen years. As a boy becomes more aware of his body, he will most likely discover how to retract his own foreskin. But foreskin retraction should never be forced. Until the foreskin fully separates, do not try to pull it back. Forcing the foreskin to retract before it is ready can cause severe pain, bleeding, and tears in the skin.

What is the white stuff under the foreskin?

When the foreskin separates from the head of the penis, skin cells are shed. These skin cells may look like white, pearl-like lumps under the foreskin. These are called *smegma.* Smegma is normal and nothing to worry about.

Is there anything special I need to teach my son?

If your son's foreskin separates before he reaches puberty, an occasional retraction with cleansing beneath will do. Once your son starts puberty, he should clean beneath his foreskin as part of his daily routine, just like washing his hair and brushing his teeth.

Teach your son to clean his foreskin in the following way:

- **Step 1:** Gently pull the foreskin back away from the end of the penis.
- **Step 2:** Rinse underneath the foreskin with soap and warm water.
- **Step 3:** Pull the foreskin back over the penis.

Is there anything else I should watch for?

While your son is still a baby, make sure the hole in the foreskin is large enough for him to urinate normally. Talk with your pediatrician if

- The urine stream is never more than a trickle.
- Your baby seems uncomfortable while urinating.
- The foreskin becomes considerably red or swollen.

From your doctor

American Academy of Pediatrics

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American Academy of Pediatrics
Web site—www.HealthyChildren.org

Baby Breakouts: Common Skin Issues Explained

You know your baby's delicate skin best, but it can still come as a surprise to learn how susceptible our little ones are to rashes and bumps. Most infant skin conditions are harmless and clear up on their own with a little TLC from mom and dad. But this quick guide offers some helpful information about a few of the most common skin concerns, and what you can do for your baby.

Diaper Rash

Diaper rash is one of the most common skin conditions in babies ages four to 15 months. It's any type of inflammation (rash or redness) that appears in the diaper area.

Diaper rash is caused by too much moisture, continual chafing and rubbing or leaving wet or dirty diapers on for too long. Diaper rash can also be an allergic reaction to the diaper material, food or other substance. Sometimes, diaper rashes can occur even if you make every effort to change your little one as quickly as possible.

In most cases, it clears up in less than a week with treatment.

Signs to look for

- Bright, red patches of skin in the diaper area
- In severe instances, open sores (in which case, you should call your pediatrician)
- Skin around the diaper area that's warm to the touch (in which case, you should call your pediatrician)

What to do

- Keep the area as clean and dry as you can
- Apply skin cream or ointment with zinc oxide or petroleum jelly to the affected area
- Avoid rubbing or scrubbing your baby's skin to avoid further irritation
- Be wary of scented wipes, which can sting red or irritated skin, until the rash has cleared – instead, rinse the area with warm water
- Keep diapers as loose as possible, especially overnight
- Soak your baby in an oatmeal bath to help soothe irritation and redness

Infant eczema

Eczema in kids usually makes an appearance between six months and five years, and is common in up to 10 percent of babies. Doctors can't say conclusively what causes it, but we do know that it's a response from your child's immune system that can result from a combination of genetic and environmental factors.

Babies who have a family history of hay fever, asthma or allergies may be more susceptible. Eczema is not contagious, and your baby can't catch it or give it to anyone else. It may require treatment from a doctor.

Signs to look for

- Patches of dry, red, scaly skin on the face, hands, back, behind the ears or in creases and folds of the elbows, neck and knees
- Small bumps on the cheeks, forehead and scalp

What to do

- Keep baby's skin moisturized
- Keep your little one from scratching as best you can, and keep her fingernails short
- Limit your child's exposure to her specific triggers, including allergens like pollen, dust and pet dander, soaps and detergents, fabrics, tobacco smoke, certain foods, heat and sweating
- Avoid hot baths and other activities that may dry out the skin, and pat skin dry rather than rubbing after bathing
- Apply protective creams and ointments, including the ones prescribed by your pediatrician, to aggravated areas, especially after bathing
- Apply cold compresses to soothe hot, itchy areas

Cradle Cap

Cradle cap is the baby version of dandruff, and there's no need to worry if it pops up on your child's scalp. It can occur in kids up to three years of age, but is most common in infants, and will usually go away on its own in a few weeks or months.

Signs to look for

- Rough white, yellow or dark patches on the scalp – this can also extend to the forehead, eyebrows and ears
- Scaling or redness on the scalp
- Crusted or greasy patches on the scalp
- Flakes that look like dandruff

What to do

- Wash baby's hair with mild shampoo and then softly brush to remove scales
- Massage baby's scalp with a washcloth to encourage the removal of flakes and scales
- Some parents find that baby oil helps ease cradle cap, but it's not necessary in most cases

Baby (neonatal) acne

Baby acne is a skin condition that causes pimples to form on an infant's cheeks, nose and forehead as a result of exposure to mom's hormones while in the womb. It appears around two to three weeks of age, and will usually clear up by the time baby is six months old.

What to look for

- Small red or pink bumps on baby's skin

What to do

- Gently clean the area with mild soap and water
- Avoid using lotions, harsh soaps or acne medication intended for adults

Your baby at 2 months

Baby's Name _____ **Baby's Age** _____ **Today's Date** _____

Milestones matter! How your baby plays, learns, speaks, acts, and moves offers important clues about his or her development. Check the milestones your baby has reached by 2 months. Take this with you and talk with your baby's doctor at every well-child visit about the milestones your baby has reached and what to expect next.

What most babies do by this age:

Social/Emotional Milestones

- ☐ Calms down when spoken to or picked up
- ☐ Looks at your face
- ☐ Seems happy to see you when you walk up to her
- ☐ Smiles when you talk to or smile at her

Language/Communication Milestones

- ☐ Makes sounds other than crying
- ☐ Reacts to loud sounds

Cognitive Milestones (learning, thinking, problem-solving)

- ☐ Watches you as you move
- ☐ Looks at a toy for several seconds

Movement/Physical Development Milestones

- ☐ Holds head up when on tummy
- ☐ Moves both arms and both legs
- ☐ Opens hands briefly

Other important things to share with the doctor...

- What are some things you and your baby do together?
- What are some things your baby likes to do?
- Is there anything your baby does or does not do that concerns you?
- Has your baby lost any skills he/she once had?
- Does your baby have any special healthcare needs or was he/she born prematurely?

You know your baby best. Don't wait. If your baby is not meeting one or more milestones, has lost skills he or she once had, or you have other concerns, act early. Talk with your baby's doctor, share your concerns, and ask about developmental screening. If you or the doctor are still concerned:

1. Ask for a referral to a specialist who can evaluate your baby more; and
2. Call your state or territory's early intervention program to find out if your baby can get services to help. Learn more and find the number at **cdc.gov/FindEI**.

For more on how to help your baby, visit **cdc.gov/Concerned**.

Don't wait.
Acting early can make a real difference!

CDC Centers for Disease Control and Prevention

Download CDC's free *Milestone Tracker* app

App Store Google Play

American Academy of Pediatrics
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Help your baby learn and grow

As your baby's first teacher, you can help his or her learning and brain development. Try these simple tips and activities in a safe way. Talk with your baby's doctor and teachers if you have questions or for more ideas on how to help your baby's development.

- Respond positively to your baby. Act excited, smile, and talk to him when he makes sounds. This teaches him to take turns "talking" back and forth in conversation.
- Talk, read, and sing to your baby to help her develop and understand language.
- Spend time cuddling and holding your baby. This will help him feel safe and cared for. You will not spoil your baby by holding or responding to him.
- Being responsive to your baby helps him learn and grow. Limiting your screen time when you are with your baby helps you be responsive.
- Take care of yourself. Parenting can be hard work! It's easier to enjoy your new baby when you feel good yourself.
- Learn to notice and respond to your baby's signals to know what she's feeling and needs. You will feel good and your baby will feel safe and loved. For example, is she trying to "play" with you by making sounds and looking at you, or is she turning her head away, yawning, or becoming fussy because she needs a break?
- Lay your baby on his tummy when he is awake and put toys at eye level in front of him. This will help him practice lifting his head up. Do not leave your baby alone. If he seems sleepy, place him on his back in a safe sleep area (firm mattress with no blankets, pillows, bumper pads, or toys).
- Feed only breast milk or formula to your baby. Babies are not ready for other foods, water or other drinks for about the first 6 months of life.
- Learn when your baby is hungry by looking for signs. Watch for signs of hunger, such as putting hands to mouth, turning head toward breast/bottle, or smacking/licking lips.
- Look for signs your baby is full, such as closing her mouth or turning her head away from the breast/bottle. If your baby is not hungry, it's ok to stop feeding.
- Do not shake your baby or allow anyone else to—ever! You can damage his brain or even cause his death. Put your baby in a safe place and walk away if you're getting upset when he is crying. Check on him every 5–10 minutes. Infant crying is often worse in the first few months of life, but it gets better!
- Have routines for sleeping and feeding. This will help your baby begin to learn what to expect.

To see more tips and activities download CDC's Milestone Tracker app.

This milestone checklist is not a substitute for a standardized, validated developmental screening tool. These developmental milestones show what most children (75% or more) can do by each age. Subject matter experts selected these milestones based on available data and expert consensus.

www.cdc.gov/ActEarly | 1-800-CDC-INFO (1-800-232-4636)

Download CDC's free *Milestone Tracker* app

Download on the App Store | GET IT ON Google Play

Learn the Signs. Act Early.

Back to Sleep, Tummy to Play

What are the 2 most important things to remember about safe sleep practices?

1. Healthy babies are safest when sleeping on their backs at nighttime and during naps. Side sleeping is not as safe as back sleeping and is not advised.
2. Tummy time is for babies who are awake and being watched. Your baby needs this to develop strong muscles.

Remember…Back to Sleep, Tummy to Play

How much tummy time should an infant have?

Beginning on his first day home from the hospital or in your family child care home or center, play and interact with the baby while he is awake and on the tummy 2 to 3 times each day for a short period of time (3-5 minutes), increasing the amount of time as the baby shows he enjoys the activity. A great time to do this is following a diaper change or when the baby wakes up from a nap.

Tummy time prepares babies for the time when they will be able to slide on their bellies and crawl. As babies grow older and stronger they will need more time on their tummies to build their own strength.

What if the baby does not like being on her tummy?

Some babies may not like the tummy time position at first. Place yourself or a toy in reach for her to play with. Eventually your baby will enjoy tummy time and begin to enjoy play in this position.

Doesn't sleeping on her back cause the baby to have a flat head?

Parents and caregivers often worry about the baby developing a flat spot on the back of the head because of sleeping on the back. Though it is possible for a baby to develop a flat spot on the head, it usually rounds out as they grow older and sit up. There are ways to reduce the risk of the baby developing a flat spot:

1. Alternate which end of the crib you place the baby's feet. This will cause her to naturally turn toward light or objects in different positions, which will lessen the pressure on one particular spot on her head.
2. When the baby is awake, vary her position. Limit time spent in freestanding swings, bouncy chairs, and car seats. These items all put added pressure on the back of the baby's head.
3. Spend time holding the baby in your arms as well as watching her play on the floor, both on her tummy and on her back.
4. A breastfed baby would normally change breasts during feeding; if the baby is bottle fed, switch the side that she feeds on during feeding.

How can I exercise the baby while he is on his tummy?

There are lots of ways to play with the baby while he is on his tummy.

1. Place yourself or a toy just out of the baby's reach during playtime to get him to reach for you or the toy.
2. Place toys in a circle around the baby. Reaching to different points in the circle will allow him to develop the appropriate muscles to roll over, scoot on his belly, and crawl.
3. Lie on your back and place the baby on your chest. The baby will lift his head and use his arms to try to see your face.
4. While keeping watch, have a young child play with the baby while on his tummy. Young children can get down on the floor easily. They generally have energy for playing with babies, may really enjoy their role as the "big kid," and are likely to have fun themselves.

Back to sleep and tummy to play

Follow these easy steps to create a safe sleep environment in your home, family child care home, or child care center:

1. Always place babies on their backs to sleep, even for short naps.
2. Place babies on a firm sleep surface that meets current safety standards. For more information about crib safety standards, visit the Consumer Product Safety Commission Web site at www.cpsc.gov.
3. Keep soft objects, loose bedding, or any objects that could increase the risk of entrapment, suffocation, or strangulation from the baby's sleep area.
4. Make sure the baby's head and face remain uncovered during sleep.
5. Place the baby in a smoke-free environment.
6. Do not let babies get too hot. Keep the room where babies sleep at a comfortable temperature. In general, dress babies in no more than one extra layer than you would wear. Babies may be too hot if they are sweating or if their chests feel hot. If you are worried that babies are cold, use a wearable blanket such as a sleeping sack or warm sleeper that is the right size for each baby. These are made to cover the body and not the head.
7. If you are working in a family child care home or center, create a written safe sleep policy to ensure that staff and families understand and practice back to sleep and sudden infant death syndrome (SIDS) and suffocation risk reduction practices in child care. If you are a parent with a child in out-of-home child care, advocate for the creation of a safe sleep policy.

National SIDS resources

Healthy Child Care America (A former program of the American Academy of Pediatrics). Visit www.healthychildcare.org/sids.html to download a free copy of *Reducing the Risk of SIDS in Child Care Speaker's Kit*, AAP policy and research articles, and more.

Caring for Our Children, National Health and Safety Performance Standards
Visit the National Resource Center for Health and Safety in Child Care and Early Education Web site at http://nrckids.org for more information.

National Institute of Child and Human Development Safe to Sleep Campaign
http://www.nichd.nih.gov/sids

CJ Foundation for SIDS
www.cjsids.com

First Candle
www.firstcandle.org

Association of SIDS and Infant Mortality Programs
www.asip1.org

Centers for Disease Control and Prevention
www.cdc.gov/sids

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From your doctor

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

American Academy of Pediatrics
Web site— www.HealthyChildren.org

5 Secrets to a Smarter Baby: School Readiness Can Start Now

As parents, we all want happy, healthy babies. Not only that, we want them to be smart.
Growing research in early brain development shows there are some basic things you can do right now to start raising a child who is curious about the world and ready to learn. These early education activities we're talking about are simple—and screen free!

The American Academy of Pediatrics (AAP) recommends parents talk with their pediatrician about how to create a supportive, stimulating environment for their baby—starting at birth—that promotes healthy brain development and builds the social and emotional skills necessary for school readiness.

Use the "5 Rs of Early Education" in your daily activities right from birth:

1. READ together as a daily, fun, family activity.
- The AAP recommends this to build language, literacy, and social-emotional skills that last a lifetime. It's never too young to start reading with your baby. Reading to your child, research suggests, boosts activity in parts of the brain that form the building blocks of language, literacy skills and imagination.

2. RHYME, play, talk, sing, and cuddle together often throughout the day.
- The AAP encourages parents to use play to help meet their child's health and developmental milestones, beginning from birth. Need ideas? Here are some great ways to do this based on your child's age. Talk with them about things they see around them, at home, at the store, or while traveling. Enroll in quality early education programs and activities, take time to visit a children's museum or local library, and enjoy story time.

3. Build ROUTINES for meals, play, and sleep.
- This helps children know what to expect and what is expected of them. Brush, Book, Bed, for example, is a great way to structure your child's nighttime routine. Eating at least three family meals together each week is associated with healthier kids, according to a study published in *Pediatrics.*

4. REWARD everyday successes (especially for effort toward goals like helping others).
- Catch your child doing something good and praise them for it! Praise from those closest to a child is a very powerful reward. Talk with your pediatrician about how to shape and manage your child's behavior, model the good behavior, and reinforce it by using positive discipline techniques that build a child's self-regulation skills. Your child's social, emotional, and behavior skills are equally critical to school success.

5. Develop RELATIONSHIPS that are nurturing, respectful, and consistent.
- A strong parent-child relationship helps protect against the lasting effects of adverse childhood experiences (ACEs), traumatic situations that can lower a child's chance of doing well in school. As you strive to teach your child about healthy relationships and choosing friends wisely, don't forget to model them in your own life. Demonstrating good relationships skills with your spouse or partner, and taking time to nurture close friendships with others, is as important as simply talking about these skills--if not more so.

You are your baby's best teacher.
A certain toy is not necessary for your child to reach his or her next developmental milestone. There is no one app that will teach your child to read. While it's easy to fall victim to the marketing, YOU are what your child needs to start on the path toward school readiness with daily reading, rhyming, routines, rewards, and relationship building.

Additional Information:

- Is Your Preschooler Ready for Kindergarten?
- The Power of Play - How Fun and Games Help Children Thrive
- Toy Buying Tips for Babies & Young Children: AAP Report Explained
- Toy Buying Tips for Children with Special Needs
- Healthy Digital Media Use Habits for Babies, Toddlers & Preschoolers
- School Readiness (AAP Technical Report)

Last Updated: 7/23/2019

Children's Healthcare of Atlanta

STRONG4LIFE

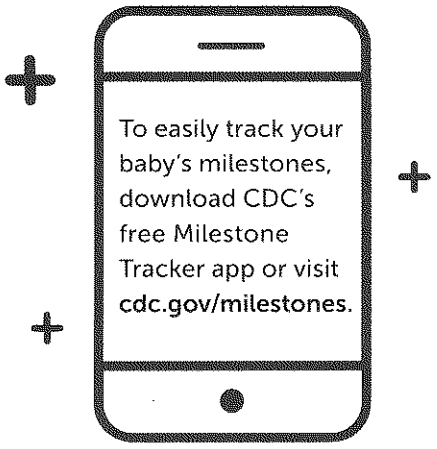
Building resilient children at 1 month old

Resilience is the ability to handle life's ups and downs.

Your newborn is changing rapidly at this point. This time is critical for building resilience to help mold your baby's long-term physical and emotional health. **Below are some tips to help your 1-month-old build resilience.**

What is happening at 1 month?

- Your baby may be more alert now and noticing the things going on around him.
- Your baby may be lifting his head and looking around during tummy time.



Getting to know your baby

Your baby is changing and growing every day. Here are some tips to help connect with and understand your new baby.

- Try to follow a simple routine each day, but remember to be flexible, as your baby's needs are rapidly changing. Try to encourage sleeping and activities to happen around the same time each day.
- Cuddle, hold and make eye contact with your baby frequently. Remember, you cannot spoil a baby at this age. Cuddling helps your baby form a safe attachment to you, which helps build self-esteem and empathy, and promotes calmness.
- Crying is normal. This is your baby's way of communicating. Respond to his cries and assess his needs. Comfort him as needed.
- Spend screen-free time with your baby. Focus on connection and make eye contact while talking, singing and playing with your baby.

Sleep

At this age, your baby may be getting 16 hours of sleep in a 24-hour period. Follow the ABCs of safe sleep (alone, on their backs, in a crib) to reduce the risk of sudden infant death syndrome (SIDS).

As your baby becomes more alert, continue to make periods of awake time during the day stimulating, while keeping nighttime interactions quiet, dark and free of stimulation (limiting lights and sounds). This will help baby to understand that nighttime is a time for sleep, and to find comfort in her sleep environment.

Your new normal

You as the parent

Your family dynamics have changed now that baby is here. It is important to remember that even very young babies pick up on stress and tension. These first few weeks are challenging for any family. So, remember to take time for yourself to rest, express your own feelings and meet your own needs. Tap into your resources, such as a partner, extended family and other parents you trust, so that you can make sure you are feeling your best, too.

Family members

Siblings may also be experiencing a lot of stress during this transition. Connect with other children in the home, and encourage them to express their feelings surrounding baby's arrival. Find simple ways to help other family members feel included during this transition period, like sitting with an older sibling and your new baby to read a book, or going for a walk as a family.

Communicating with your baby

It's important to start talking about feelings with your baby, even at a young age, so that she can express those feelings on her own later.

- Make eye contact with your baby, mimic the expressions she is making and comment on her expressions.
- Speak to your baby in a calm, rhythmic and soothing voice.
- Respond to her cries and assess and meet her needs. You cannot spoil a baby at this age.
- Change your location. If your baby is overstimulated, take her to a calm space, in another room or outside.

Q&A THE FACTS ABOUT CHILDHOOD VACCINES: WHAT YOU SHOULD KNOW

Volume 11
Summer 2020

Q. How can parents sort out conflicting information about vaccines?
A. Decisions about vaccine safety must be based on well-controlled scientific studies.

Parents are often confronted with "scientific" information found on television, on the internet, in magazines and in books that conflicts with information provided by healthcare professionals. But few parents have the background in microbiology, immunology, epidemiology and statistics to separate good scientific studies from poor studies. Parents and physicians benefit from the expert guidance of specialists with experience and training in these disciplines.

Committees of these experts are composed of scientists, clinicians and other caregivers who are as passionately devoted to our children's health as they are to their own children's health. They serve the Centers for Disease Control and Prevention (cdc.gov/vaccines), the American Academy of Pediatrics (aap.org), the American Academy of Family Physicians (aafp.org), the American College of Obstetricians and Gynecologists (acog.org), and the National Foundation of Infectious Diseases (nfid.org), among other groups. These organizations provide excellent information to parents and healthcare professionals through their websites. Their task is to determine whether scientific studies are carefully performed, published in reputable journals and, most importantly, reproducible. Information that fails to meet these standards is viewed as unreliable.

When it comes to issues of vaccine safety, these groups have served us well. They were the first to figure out that intestinal blockage was a rare consequence of the first rotavirus vaccine, and the vaccine was quickly discontinued. And, they recommended a change from the oral polio vaccine, which was a rare cause of paralysis, to the polio shot when it was clear that the risks of the oral polio vaccine outweighed its benefits.

These groups have also investigated possible relationships between vaccines and asthma, diabetes, multiple sclerosis, SIDS and autism. No studies have reliably established a causal link between vaccines and these diseases — if they did, the questioned vaccines would be withdrawn from use.

Q. Are vaccines still necessary?
A. Although several of the diseases that vaccines prevent have been dramatically reduced or eliminated, vaccines are still necessary:

• *To prevent common infections*

Some diseases are so common that a choice not to get a vaccine is a choice to get infected. For example, choosing not to get the pertussis (whooping cough) vaccine is a choice to risk a serious and occasionally fatal infection.

• *To prevent infections that could easily re-emerge*

Some diseases can easily re-emerge with relatively small decreases in immunization rates (for example, measles, mumps and *Haemophilus influenzae* type b, or Hib). We have seen this with measles and mumps. Unvaccinated children are more likely to be infected.

• *To prevent infections that are common in other parts of the world*

Although some diseases have been completely eliminated (polio) or virtually eliminated (diphtheria) from this country, they still occur commonly in other parts of the world. Children are still paralyzed by polio and sickened by diphtheria in other areas of the world. Because there is a high rate of international travel, outbreaks of these diseases are only a plane ride away.

Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases*. 13th Edition. Hamborsky J, Kroger A, and Wolfe S. eds. Washington, DC: Public Health Foundation; 2015 and Supplement, 2017.

Q. Do vaccines contain additives?
A. Many vaccines contain trace quantities of antibiotics or stabilizers.

Antibiotics are used during the manufacture of vaccines to prevent inadvertent contamination with bacteria or fungi. Trace quantities of antibiotics are present in some vaccines. However, the antibiotics contained in vaccines (neomycin, streptomycin or polymyxin B) are not those commonly given to children. Therefore, children with allergies to antibiotics such as penicillin, amoxicillin, sulfa or cephalosporins can still get vaccines.

Gelatin is used to stabilize live, "weakened" viral vaccines and is also contained in many food products. People with known allergies to gelatin contained in foods may have severe allergic reactions to the gelatin contained in vaccines. However, this reaction is extremely rare.

Offit PA, Jew RK. Addressing parents' concerns: Do vaccines contain harmful preservatives, adjuvants, additives, or residuals? *Pediatrics.* 2003;112:1394-1401.

American Academy of Pediatrics. In Kimberlin DW, ed. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st Edition. Elk Grove Village, IL.

Q. Are vaccines made using fetal cells?
A. Viruses require cells in which to reproduce. This means to make viral vaccines, the viruses must be grown in cells in the laboratory. In a few cases, the types of cells chosen were from pregnancies that were terminated electively. The scientists made this decision for two reasons. First, viruses that infect people reproduce best in cells from people. Second, cells isolated from a fetus are not likely to contain viruses because the womb is sterile.

The fetal cells used to grow vaccine viruses were isolated from two elective abortions that occurred in the early 1960s. The cells have been grown in the laboratory since then, and no additional abortions are needed to make the vaccines.

The vaccines made using these cell lines include the chickenpox, rubella (part of MMR), hepatitis A, and rabies (one version) vaccines.

Q. Are vaccines safe?
A. Because vaccines are given to people who are not sick, they are held to the highest standards of safety. As a result, they are among the safest things we put into our bodies.

How does one define the word safe? If safe is defined as "free from any negative effects," then vaccines aren't 100% safe. All vaccines have possible side effects. Most side effects are mild, such as fever, or tenderness and swelling where the shot is given. But some side effects from vaccines can be severe. For example, the pertussis vaccine is a very rare cause of persistent, inconsolable crying, high fever or seizures with fever. Although these reactions do not cause permanent harm to the child, they can be quite frightening.

If vaccines cause side effects, wouldn't it be "safer" to just avoid them? Unfortunately, choosing to avoid vaccines is not a risk-free choice — it is a choice to take a different and much more serious risk. Discontinuing the pertussis vaccine in countries like Japan and England led to a tenfold increase in hospitalizations and deaths from pertussis. And declines in the number of children receiving measles vaccine in the United Kingdom and the United States have led to increases in cases of measles.

When you consider the risk of vaccines and the risk of diseases, vaccines are the safer choice.

Plotkin S, et al. *Vaccines*. 7th Edition. Philadelphia, PA: W.B. Elsevier, 2017.

Q. How can a "one-size-fits-all" approach to vaccines be OK for all children?
A. The recommended immunization schedule is not the same for all children.

In fact, recommendations for particular vaccines often vary based upon individual differences in current and long-term health status, allergies and age. Each vaccine recommendation, often characterized by a single line on the immunization schedule, is supported by about 25 to 40 additional pages of specific instructions for healthcare providers who administer vaccines. In addition, an approximately 190-page document titled "General Best Practice Guidelines for Immunization" serves as the basis for all vaccine administration. The recommendations are updated as needed by the CDC, and a comprehensive update is published every few years.

continued>

Children's Hospital of Philadelphia®
Vaccine Education Center

Q&A THE FACTS ABOUT CHILDHOOD VACCINES: WHAT YOU SHOULD KNOW

Q. Is the amount of aluminum in vaccines safe?

A. Yes. All of us have aluminum in our bodies and most of us are able to process it effectively. The two main groups of people who cannot process aluminum effectively are severely premature infants who receive large quantities of aluminum in intravenous fluids and people who have long-term kidney failure and receive large quantities of aluminum, primarily in antacids. In both cases, the kidneys are not working properly or at all and the people are exposed to large quantities of aluminum over a long period of time.

The amount of aluminum in vaccines given during the first six months of life is about 4 milligrams, or four-thousandths of a gram. A gram is about one-fifth of a teaspoon of water. In comparison, breast milk ingested during this period will contain about 10 milligrams of aluminum, and infant formulas will contain about 40 milligrams. Soy-based formulas contain about 120 milligrams of aluminum.

When studies were performed to look at the amount of aluminum injected in vaccines, the levels of aluminum in blood did not detectably change. This indicates that the quantity of aluminum in vaccines is minimal as compared with the quantities already found in the blood.

Baylor NW, Egan W, Richman P. Aluminum salts in vaccines – U.S. perspective. *Vaccine*. 2002;20:S18-S23.

Bishop NJ, Morley R, Day JP, Lucas A. Aluminum neurotoxicity in preterm infants receiving intravenous-feeding solutions. *New Engl J Med*. 1997;336:1557-1561.

Committee on Nutrition: Aluminum toxicity in infants and children. *Pediatrics*. 1996;97:413-416.

Ganrot PO. Metabolism and possible health effects of aluminum. *Env. Health Perspective*. 1986;65:363-441.

Keith LS, Jones DE, Chou C. Aluminum toxicokinetics regarding infant diet and vaccinations. *Vaccine*. 2002;20:S13-S17.

Pennington JA. Aluminum content of food and diets. *Food Additives and Contam*. 1987;5:164-232.

Simmer K, Fudge A, Teubner J, James SL. Aluminum concentrations in infant formula. *J Peds and Child Health*. 1990;26:9-11.

Q. Do vaccines cause autism?

A. Carefully performed studies clearly disprove the notion that vaccines cause autism.

Because the signs of autism may appear in the second year of life, at around the same time children receive certain vaccines, and because all causes of autism are unknown, some parents wondered whether vaccines might be at fault. These concerns focused on three hypotheses — autism is caused by the measles-mumps-rubella (MMR) vaccine; thimerosal, an ethylmercury-containing preservative used in vaccines; or receipt of too many vaccines too soon.

A large body of medical and scientific evidence strongly refutes these notions. Multiple studies have found that vaccines do not cause autism. These studies included hundreds of thousands of children, occurred in multiple countries, were conducted by multiple investigators, and were well controlled.

To see summaries of some of these studies and other studies related to vaccine safety concerns, visit vaccine.chop.edu/safety-references.

To find the most up-to-date information about the causes of autism, visit the Autism Science Foundation website, autismsciencefoundation.org.

Q. Does my child still need to get vaccines if I am breastfeeding?

A. Yes. The types of immunity conferred by breastfeeding and immunization are different. Specifically, the antibodies that develop after immunization are made by the baby's own immune system and, therefore, will remain in the form of immunologic memory; this is known as active immunity. In contrast, antibodies in breast milk were made by the maternal immune system, so they will provide short-term protection, but will not last more than a few weeks. These antibodies are usually not as diverse either, so the baby may be protected against some infections but remain susceptible to others. Immunity generated from breast milk is called passive immunity. Passive immunity was practiced historically when patients exposed to diphtheria were given antitoxin produced in horses; antitoxins to snake venoms are also an example of passive immunity.

Q. Do children get too many shots?

A. Newborns commonly manage many challenges to their immune systems at the same time.

Because some children could receive as many as 27 vaccine doses by the time they are 2 years old and as many as six shots in a single visit to the doctor, many parents wonder whether it is safe to give children so many vaccines.

Although the mother's womb is free from bacteria and viruses, newborns immediately face a host of different challenges to their immune systems. From the moment of birth, thousands of different bacteria start to live on the surface of the skin and intestines. By quickly making immune responses to these bacteria, babies keep them from invading the bloodstream and causing serious diseases.

In fact, babies are capable of responding to millions of different viruses and bacteria because they have billions of immunologic cells circulating in the bodies. Therefore, vaccines given in the first two years of life are a raindrop in the ocean of what an infant's immune system successfully encounters and manages every day.

Offit PA, et al. Addressing parents' concerns: Do vaccines weaken or overwhelm the infant's immune system? *Pediatrics*. 2002;109:124-129.

Q. What is the harm of separating, spacing out or withholding some vaccines?

A. Although the vaccine schedule can look intimidating, it is based upon the best scientific information available and is better tested for safety than any alternative schedules.

Experts review studies designed to determine whether the changes are safe in the context of the existing schedule. These are called concomitant use studies.

Separating, spacing out or withholding vaccines causes concern because infants will be susceptible to diseases for longer periods of time. When a child should receive a vaccine is determined by balancing when the recipient is at highest risk of contracting the disease and when the vaccine will generate the best immune response.

Finally, changing the vaccine schedule requires additional doctor's visits. Research measuring cortisol, a hormone associated with stress, has determined that children do not experience more stress when receiving two shots as compared with one shot. Therefore, an increased number of visits for individual shots will mean an increase in the number of stressful situations for the child without benefit. In addition, there is an increased potential for administration errors, more time and travel needed for appointments, potentially increased costs and the possibility that the child will never get some vaccines.

Cohn M, Langman RE. The protection: the unit of humoral immunity selected by evolution. *Immunol Rev*. 1990;115:9-147.

Offit PA, Quarels J. Gerber MA, et al. Addressing parents' concerns: Do multiple vaccines overwhelm or weaken the infant's immune system? *Pediatrics*. 2002;109:124-129.

Ramsay DS, Lewis M. Developmental changes in infant cortisol and behavioral response to inoculation. *Child Dev*. 1994;65:1491-1502.

Tonegawa S, Steinberg C, Dube S, Bernardini A. Evidence for somatic generation of antibody diversity. *Proc Natl Acad Sci USA*. 1974;71:4027-4031.

This information is provided by the Vaccine Education Center at Children's Hospital of Philadelphia. The Center is an educational resource for parents and healthcare professionals and is composed of scientists, physicians, mothers and fathers who are devoted to the study and prevention of infectious diseases. The Vaccine Education Center is funded by endowed chairs from Children's Hospital of Philadelphia. The Center does not receive support from pharmaceutical companies.

Children's Hospital of Philadelphia®
Vaccine Education Center

Learn more: vaccine.chop.edu

Your Child's First Vaccines:

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

The vaccines included on this statement are likely to be given at the same time during infancy and early childhood. There are separate Vaccine Information Statements for other vaccines that are also routinely recommended for young children (measles, mumps, rubella, varicella, rotavirus, influenza, and hepatitis A).

Your child is getting these vaccines today:

☐ DTaP ☐ Hib ☐ Hepatitis B ☐ Polio ☐ PCV13

(Provider: Check appropriate boxes.)

1 Why get vaccinated?

Vaccines can prevent disease. Most vaccine-preventable diseases are much less common than they used to be, but some of these diseases still occur in the United States. **When fewer babies get vaccinated, more babies get sick.**

Diphtheria, tetanus, and pertussis

- Diphtheria (D) can lead to difficulty breathing, heart failure, paralysis, or death.
- Tetanus (T) causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- Pertussis (aP), also known as "whooping cough," can cause uncontrollable, violent coughing which makes it hard to breathe, eat, or drink. Pertussis can be extremely serious in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

Hib (*Haemophilus influenzae* type b) disease

Haemophilus influenzae type b can cause many different kinds of infections. These infections usually affect children under 5 years old. Hib bacteria can cause mild illness, such as ear infections or bronchitis, or they can cause severe illness, such as infections of the bloodstream. Severe Hib infection requires treatment in a hospital and can sometimes be deadly.

Hepatitis B

Hepatitis B is a liver disease. Acute hepatitis B infection is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements), and pain in the muscles, joints, and stomach. Chronic hepatitis B infection is a long-term illness that is very serious and can lead to liver damage (cirrhosis), liver cancer, and death.

Polio

Polio is caused by a poliovirus. Most people infected with a poliovirus have no symptoms, but some people experience sore throat, fever, tiredness, nausea, headache, or stomach pain. A smaller group of people will develop more serious symptoms that affect the brain and spinal cord. In the most severe cases, polio can cause weakness and paralysis (when a person can't move parts of the body) which can lead to permanent disability and, in rare cases, death.

Pneumococcal disease

Pneumococcal disease is any illness caused by pneumococcal bacteria. These bacteria can cause pneumonia (infection of the lungs), ear infections, sinus infections, meningitis (infection of the tissue covering the brain and spinal cord), and bacteremia (bloodstream infection). Most pneumococcal infections are mild, but some can result in long-term problems, such as brain damage or hearing loss. Meningitis, bacteremia, and pneumonia caused by pneumococcal disease can be deadly.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

2 DTaP, Hib, hepatitis B, polio, and pneumococcal conjugate vaccines

Infants and children usually need:

- 5 doses of **diphtheria, tetanus, and acellular pertussis vaccine (DTaP)**
- 3 or 4 doses of **Hib vaccine**
- 3 doses of **hepatitis B vaccine**
- 4 doses of **polio vaccine**
- 4 doses of **pneumococcal conjugate vaccine (PCV13)**

Some children might need fewer or more than the usual number of doses of some vaccines to be fully protected because of their age at vaccination or other circumstances.

Older children, adolescents, and adults with certain health conditions or other risk factors might also be recommended to receive 1 or more doses of some of these vaccines.

These vaccines may be given as stand-alone vaccines, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

3 Talk with your health care provider

Tell your vaccine provider if the child getting the vaccine:

For all vaccines:

- Has had an **allergic reaction after a previous dose of the vaccine**, or has any **severe, life-threatening allergies**.

For DTaP:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis.**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP or DTaP).**
- Has **seizures or another nervous system problem.**
- Has ever had **Guillain-Barré Syndrome** (also called GBS).
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria.**

For PCV13:

- Has had an **allergic reaction after a previous dose of PCV13, to an earlier pneumococcal conjugate vaccine known as PCV7, or to any vaccine containing diphtheria toxoid** (for example, DTaP).

In some cases, your child's health care provider may decide to postpone vaccination to a future visit.

Children with minor illnesses, such as a cold, may be vaccinated. Children who are moderately or severely ill should usually wait until they recover before being vaccinated.

Your child's health care provider can give you more information.

4 Risks of a vaccine reaction

For DTaP vaccine:

- Soreness or swelling where the shot was given, fever, fussiness, feeling tired, loss of appetite, and vomiting sometimes happen after DTaP vaccination.
- More serious reactions, such as seizures, non-stop crying for 3 hours or more, or high fever (over 105°F) after DTaP vaccination happen much less often. Rarely, the vaccine is followed by swelling of the entire arm or leg, especially in older children when they receive their fourth or fifth dose.
- Very rarely, long-term seizures, coma, lowered consciousness, or permanent brain damage may happen after DTaP vaccination.

For Hib vaccine:

- Redness, warmth, and swelling where the shot was given, and fever can happen after Hib vaccine.

For hepatitis B vaccine:

- Soreness where the shot is given or fever can happen after hepatitis B vaccine.

For polio vaccine:

- A sore spot with redness, swelling, or pain where the shot is given can happen after polio vaccine.

For PCV13:

- Redness, swelling, pain, or tenderness where the shot is given, and fever, loss of appetite, fussiness, feeling tired, headache, and chills can happen after PCV13.
- Young children may be at increased risk for seizures caused by fever after PCV13 if it is administered at the same time as inactivated influenza vaccine. Ask your health care provider for more information.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Rotavirus Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Rotavirus vaccine can prevent **rotavirus disease**.

Rotavirus causes diarrhea, mostly in babies and young children. The diarrhea can be severe, and lead to dehydration. Vomiting and fever are also common in babies with rotavirus.

2 Rotavirus vaccine

Rotavirus vaccine is administered by putting drops in the child's mouth. Babies should get 2 or 3 doses of rotavirus vaccine, depending on the brand of vaccine used.

- The first dose must be administered before 15 weeks of age.
- The last dose must be administered by 8 months of age.

Almost all babies who get rotavirus vaccine will be protected from severe rotavirus diarrhea.

Another virus called porcine circovirus (or parts of it) can be found in rotavirus vaccine. This virus does not infect people, and there is no known safety risk. For more information, see **http://wayback.archive-it.org/7993/20170406124518/https:/www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm212140.htm**.

Rotavirus vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of rotavirus vaccine**, or has any severe, life-threatening allergies.
- Has a **weakened immune system**.
- Has **severe combined immunodeficiency** (SCID).
- Has had a type of bowel blockage called **intussusception**.

In some cases, your child's health care provider may decide to postpone rotavirus vaccination to a future visit.

Infants with minor illnesses, such as a cold, may be vaccinated. Infants who are moderately or severely ill should usually wait until they recover before getting rotavirus vaccine.

Your child's health care provider can give you more information.

4 Risks of a vaccine reaction

- Irritability or mild, temporary diarrhea or vomiting can happen after rotavirus vaccine.

Intussusception is a type of bowel blockage that is treated in a hospital and could require surgery. It happens naturally in some infants every year in the United States, and usually there is no known reason for it. There is also a small risk of intussusception from rotavirus vaccination, usually within a week after the first or second vaccine dose. This additional risk is estimated to range from about 1 in 20,000 US infants to 1 in 100,000 US infants who get rotavirus vaccine. Your health care provider can give you more information.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

5 What if there is a serious problem?

For intussusception, look for signs of stomach pain along with severe crying. Early on, these episodes could last just a few minutes and come and go several times in an hour. Babies might pull their legs up to their chest. Your baby might also vomit several times or have blood in the stool, or could appear weak or very irritable. These signs would usually happen during the first week after the first or second dose of rotavirus vaccine, but look for them any time after vaccination. If you think your baby has intussusception, contact a health care provider right away. If you can't reach your health care provider, take your baby to a hospital. Tell them when your baby got rotavirus vaccine.

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

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Vaccine Safety: The Facts

Some people have expressed concerns about vaccine safety. **The fact is vaccines save lives and protect against the spread of disease.** If you decide not to immunize, you're not only putting your child at risk to catch a disease that is dangerous or deadly but also putting others in contact with your child at risk. Getting vaccinated is much better than getting the disease.

Indeed, some of the most devastating diseases that affect children have been greatly reduced or eradicated completely thanks to vaccination. **Today, we protect children and teens from 16 diseases that can have a terrible effect on their young victims if left unvaccinated.**

Your pediatrician knows that you care about your child's health and safety. That's why you need to get all the scientific facts from a medical professional you can trust before making any decisions based on stories you may have seen or heard on TV, the Internet, or from other parents.

Your pediatrician cares about your child, too, and wants you to know that...

- **Vaccines work.** They have kept children healthy and have saved millions of lives for more than 50 years. Most childhood vaccines are 90% to 99% effective in preventing disease. And if a vaccinated child does get the disease, the symptoms are usually less serious than in a child who hasn't been vaccinated. There may be mild side effects, like swelling where the shot was given, but they do not last long. And it is rare for side effects to be serious.
- **Vaccines are safe.** Before a vaccine is licensed in the United States, the Food and Drug Administration (FDA) reviews all aspects of development, including where and how the vaccine is made and the studies that have been conducted in people who received the vaccine. The FDA will not license a vaccine unless it meets standards for effectiveness (how well the vaccine works) and safety. Results of studies get reviewed again by the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, and the American Academy of Family Physicians before a licensed vaccine is officially recommended to be given to children. Every lot of vaccine is tested to ensure quality (including safety) before the vaccine reaches the public. In addition, FDA regularly inspects places where vaccines are made.

  Watch the Journey of Your Child's Vaccine @ https://youtu.be/Fcvgp6gNh6o.
  Learn about the three phases of clinical trials, vaccine licensing and manufacturing, how a vaccine is added to the U.S. Recommended Immunization Schedule, and how FDA and CDC monitor vaccine safety after the public begins using the vaccine.

- **Vaccines are necessary.** Your pediatrician believes that your children should receive all recommended childhood vaccines. In the United States vaccines have protected children and continue to protect children from many diseases. However, in many parts of the world many vaccine-preventable diseases that are rarely seen in the United States are still common. Since some vaccine-preventable diseases still occur in the United States and others may be brought

into the United States by Americans who travel abroad or from people visiting areas with current disease outbreaks, it's important that your children are vaccinated.
- **Vaccines are studied.** To monitor the safety of vaccines after licensure, the FDA and the CDC created the Vaccine Adverse Event Reporting System (VAERS). All doctors must report certain side effects of vaccines to VAERS. Parents can also file reports with VAERS. For more information about VAERS, visit www.vaers.hhs.gov or call the toll-free VAERS information line at 800/822-7967. Other systems exist to further study vaccine safety concerns if they are identified in VAERS by FDA and CDC.

Protection for everyone

Just as important as the initial vaccinations are the booster shots. These are designed to continue immunity by building on the previous vaccines' effectiveness. Unfortunately, some parents forget or skip the boosters, which undercut the effectiveness of a very important concept in vaccination: *herd immunity*. Herd immunity is the benefit everyone receives from a vaccinated population once immunization reaches a critical level. When enough people are vaccinated, everyone—including those who are too young or too sick to be immunized—receives some protection from the spread of diseases. However, relying on herd immunity to keep your child safe is risky. The more parents that follow this way of thinking, the fewer vaccinated children we will have, and the more likely a serious disease will return and infect all of those unvaccinated.

In the rare case that a child has serious side effects to a vaccine, parents can contact the National Vaccine Injury Compensation Program (VICP) at 800/338-2382 or www.hrsa.gov/vaccinecompensation. This federal program was created to help pay for the care of people who have been harmed.

If you have any additional questions or concerns, feel free to ask your pediatrician.

Additional Information & Resources:

- Vaccine Studies: Examine the Evidence
- Vaccines Your Child Needs
- Weighing the Risks and Benefits
- www.fda.gov (Food and Drug Administration)
- www.cdc.gov/vaccines (Centers for Disease Control and Prevention)

Last Updated: 10/10/2018
Source: Adapted from Healthy Children E-Magazine, Back to School 2012

Tips for a Less Stressful Shot Visit

Making the choice to vaccinate your child is vital for their health and well-being. Even so, getting shots can still be stressful for you and your little one. Fortunately, there are simple ways you can support your child before, during, and after shots.

Help children see vaccines as a good thing. Never threaten your child with shots, by saying "If you misbehave I will have the nurse give you a shot." Instead, remind children that vaccines can keep them healthy.

Ways to soothe your baby:

- *Swaddling*
- *Skin-to-skin contact*
- *Offering a sweet beverage, like juice (when the child is older than 6 months)*
- *Breastfeeding*

Your health care professional may cool or numb the injection site to reduce the pain associated with your child's shots.

Before Getting Shots

Come prepared! Take these steps before your child gets a shot to help make the immunization visit less stressful on you both.

- Read any vaccine materials you received from your child's health care professional and write down any questions you may have.
- Find your child's personal immunization record and bring it to your appointment. An up-to-date record tells your doctor exactly what shots your child has already received.
- Pack a favorite toy or book, and a blanket that your child uses regularly to comfort your child.

For older children

- Be honest with your child. Explain that shots can pinch or sting, but that it won't hurt for long.
- Engage other family members, especially older siblings, to support your child.
- Avoid telling scary stories or making threats about shots.

At the Doctor's Office

If you have questions about immunizations, ask your child's doctor or nurse. Before you leave the appointment, ask your child's doctor for advice on using non-aspirin pain reliever and other steps you can take at home to comfort your child.

Try these ideas for making the shots easier on your child.

- Distract and comfort your child by cuddling, singing, or talking softly.
- Smile and make eye contact with your child. Let your child know that everything is ok.
- Comfort your child with a favorite toy or book. A blanket that smells familiar will help your child feel more comfortable.
- Hold your child firmly on your lap, whenever possible.

The Centers for Disease Control and Prevention (CDC), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP) adapted this information from *Be There for Your Child during Shots*, California Department of Public Health Immunization Branch.

CS218609

For older children

- Take deep breaths with your child to help "blow out" the pain.
- Point out interesting things in the room to help create distractions.
- Tell or read stories.
- Support your child if he or she cries. Never scold a child for not "being brave."

Remember to schedule your next visit! Staying current with your child's immunizations provides the best protection against disease.

Once your child has received all of the shots, be especially supportive. Hold, cuddle, and, for infants, breastfeed or offer a bottle. A soothing voice, combined with praise and hugs will help reassure your child that everything is ok.

After the Shots

Sometimes children experience mild reactions from vaccines, such as pain at the injection site, a rash or a fever. These reactions are normal and will soon go away. The following tips will help you identify and minimize mild side effects.

- Review any information your doctor gives you about the shots, especially the Vaccine Information Statements or other sheets that outline which side effects might be expected.
- Use a cool, wet cloth to reduce redness, soreness, and swelling in the place where the shot was given.
- Reduce any fever with a cool sponge bath. If your doctor approves, give non-aspirin pain reliever.
- Give your child lots of liquid. It's normal for some children to eat less during the 24 hours after getting vaccines.
- Pay extra attention to your child for a few days. If you see something that concerns you, call your doctor.

Take a moment to read the Vaccine Information Sheet your health care professional gives you during your visit. This sheet has helpful information and describes possible side effects your child may experience.

VACCINES FOR CHILDREN PROGRAM (VFC)

INFORMATION FOR PARENTS FROM CDC

GET HELP PAYING FOR YOUR CHILD'S VACCINES!

How can I get help paying for my child's vaccines?

Since 1994, parents have been protecting their children through the VFC Program. This program provides free vaccines to children whose parents need help paying for them.

Is my child eligible for the VFC Program?

Your child is eligible if it is before his or her 19th birthday, and if he or she is one of the following:

- Medicaid-eligible
- Uninsured
- American Indian or Alaska Native
- Underinsured (Underinsured children are only eligible for VFC Vaccines through Federally Qualified Health Centers and Rural Health Clinics.)

What do you mean by "underinsured?"

Underinsured means your child has health insurance, but it won't cover the vaccine(s) because:

- It doesn't cover any vaccines.
- It doesn't cover certain vaccines.
- It covers vaccines, but it has a fixed dollar limit or cap for vaccines. Once that fixed dollar amount has been reached, your child is eligible.

Where can I go to get my child vaccinated?

Ask your doctor if he or she is a VFC Program provider. There are over 40,000 doctors enrolled in the VFC Program nationwide.

How much will I have to pay?

All vaccines are free through the VFC Program, saving you $100 or more on some vaccines. Even though you're saving a great deal of money by getting free vaccines, there can be other costs to the VFC visit:

- Doctors can charge a fee to give each shot. However, VFC vaccines cannot be denied to an eligible child if the family cannot afford the fee.
- There can be a fee for the office visit.
- There can be fees for non-vaccines services, like an eye exam or a blood test.

My child's doctor isn't a VFC provider. Where can I take my child for vaccines?

If your child's doctor isn't a VFC provider, you can take your child to one of the following places to get VFC vaccines:

- Public Health Clinic
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)

The best place to take your child depends on where you live and how your child is eligible for the VFC Program. Before you go, contact your state's VFC coordinator and ask where you should take your child for vaccines. You can find your state's VFC coordinator at this website: **www.cdc.gov/vaccines/programs/vfc/contacts-state.html**. Or call **1-800-CDC-INFO (232-4636)**. Ask for the phone number for your state's VFC coordinator.

For more information about the VFC Program, you can go to CDC's VFC webpage at **www.cdc.gov/vaccines/programs/vfc/** or call **1-800-CDC-INFO (232-4636)** and ask for information about the VFC Program.

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Tylenol or Motrin before or after vaccines?

Studies have shown that only about 5-7% of children have fevers after childhood vaccines. Other studies have shown that pre-treating children before vaccines or treating Tylenol (acetaminophen) or Motrin (ibuprofen) after vaccines can make the vaccines not work as well.

Therefore, **Northside Pediatrics** does not recommend pre-treating children with Tylenol or Motrin, or routinely giving them after the vaccines have been given. If your child *is* I n the small percentage of children that has a fever greater than 101 and/or acts irritable after vaccines and regular comfort measures do not help, then it is ok to use Tylenol or Motrin sparingly. Please refer to our dosing charts below.

Kitchen Spoons Are Not Accurate Measures

PLEASE DO NOT USE KITCHEN SPOONS TO ADMINISTER ANY MEDICATION, THESE ARE NOT ACCURATE.
USE A SYRINGE OR MEDICINE CUP PROVIDED WITH THE MEDICATION.

Acetaminophen (Tylenol or another brand): How much to give?

Give every 4 to 6 hours, as needed, no more than 5 times in 24 hours (unless directed to do otherwise by your healthcare provider.)

CHILD'S WEIGHT	CHILD'S AGE	INFANT'S NEW FORMULATION OR CHILDREN'S LIQUID 160 mg in each 5 mL	JUNIOR STRENGTH 160 mg in each tab
6-11 lbs (2.7-5 kg)	0-3 mos	Advised dose* 1.25 mL	
12-17 lbs (5.5-7.7 kg)	4-11 mos	2.5 mL	
18-23 lbs (8.2-10.5 kg)	12-23 mos	3.75 mL	
24-35 lbs (10.9-15.9 kg)	2-3 yrs	5 mL	
36-47 lbs (16.4-21.4 kg)	4-5 yrs	7.5 mL	
48-59 lbs (21.8-26.8 kg)	6-8 yrs	10 mL	2 tablets
60-71 lbs (27.3-32.3 kg)	9-10 yrs	12.5 mL	2 ½ tablets
72-95 lbs (32.7-43.2 kg)	11 yrs	15 mL	3 tablets

Ibuprofen (Advil, Motrin, or another brand): How much to give?

Give every 6 to 8 hours, as needed, no more than 4 times in 24 hours (unless directed to do otherwise by your healthcare provider.)

CHILD'S WEIGHT	CHILD'S AGE	INFANTS' DROPS 50 mg in each 1.25 mL	CHILDREN'S LIQUID 100 mg in each 5 mL	CHILDREN'S CHEWABLES OR JUNIOR TABLETS 100 mg in each tab
less than 11 lbs (2.7-5 kg)	0-5 mos	**Not recommended for babies less than 6 mos old**	**Not recommended for babies less than 6 mos old**	
12-17 lbs (5.5-7.7 kg)	6-11 mos	1.25 mL	Advised dose* _____	
18-23 lbs (8.2-10.5 kg)	12-23 mos	1.875 mL	Advised dose* _____	
24-35 lbs (10.9-15.9 kg)	2-3 yrs	2.5 mL	5 mL	1 tablet
36-47 lbs (16.4-21.4 kg)	4-5 yrs	4 mL	7.5 mL	1 ½ tablets
48-59 lbs (21.8-26.8 kg)	6-8 yrs		10 mL	2 tablets
60-71 lbs (27.3-32.3 kg)	9-10 yrs		12.5 mL	2 ½ tablets
72-95 lbs (32.7-43.2 kg)	11 yrs		15 mL	3 tablets

***HEALTHCARE PROVIDER: PLEASE FILL IN THE ADVISED DOSE.**

Immunization Action Coalition▪www.immunize.org/catg.d/p4015.pdf

5/2017