NEWBORN AND CHILDCARE HANDBOOK

Charles V. Terry, M.D.
Jocelyn B. Vergara, M.D.
Peter S. Heyman, M.D.
Lora G. Christian, M.D.
Melani B. deSilva, M.D.
Christine W. Seliskar, M.D.
William C. Hawthorne, D.O.
Tina Goodwin, C.P.N.P.
Kirsten C. Slagle, C.P.N.P., CLC
Elizabeth G. Downey, C.P.N.P.
Tiffany C. Lancaster, C.P.N.P.
E. Thornton Beale, C.P.N.P., IBCLC
Caroline Hughes, C.P.N.P.
Kathryn Golay, C.P.N.P.
Ann Wallace Tazewell, P.A.- C.
Tammy J. Rockwell, R.N., IBCLC

OFFICE LOCATIONS

Ridgefield Location
10410 Ridgefield Parkway
Richmond, VA 23233
804-754-3776

Patterson Location
7000 Patterson Avenue
Richmond, VA 23226
804-282-9706

Southside Location
14400 Sommerville Court
Midlothian, VA 23113
804-379-5437

Nights and Weekends 1-877-819-0320
www.rvapediatrics.com

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Name: _____
Date of Birth: _____
Birth Weight: _____lbs. _____oz.
Birth Length: _____

"When I look upon a child, I am filled with admiration for that child- not so much for what it is today, as for what it may become."

Louis Pasteur

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INTRODUCTION

Congratulations on the arrival of your new baby and welcome to our practice. We appreciate the opportunity to provide your pediatric and adolescent care. This booklet contains basic information concerning the care of your newborn infant and common pediatric problems.

The rearing of children is challenging and at times frustrating, but ultimately tremendously rewarding. All new parents are anxious with a new baby at home. It will come as no surprise that parenting skills are learned and not inborn. Despite the vast quantity of helpful (confusing) advice from family and friends, you will quickly gain the confidence necessary to care for your child. Luckily there are no absolutely correct ways to deal with newborn problems. Your parental instincts and common sense are usually quite appropriate. Our practice is available to answer any questions and we hope that you will call if you feel it is necessary.

During your hospital stay, your baby will be taken care of by pediatricians who are based in the hospital. Once you are discharged from the hospital and arrive at home, it is often the case that there are more questions than you imagined. It is best to set up your child's first appointment with us within 24-48 hours of going home. The hospital may recommend that you bring your child in within 24 hours if your infant has had jaundice, significant weight loss, or other medical concerns.

We offer consultation appointments, at our Patterson office, with our in-house lactation specialist, Tammy Rockwell, R.N., IBCLC. These visits are offered from Monday thru Friday between 8am-5pm.

GENERAL OFFICE INFORMATION

All three of our locations are open as follows:

Monday – Friday	8:00 A.M. – 12:30 P.M.
	2:00 P.M. – 5:00 P.M.

Additionally, our **Ridgefield** location is open Saturday & Sunday for sick visits:
Saturday – Sunday 8:00 A.M. – 12:00 P.M.

Well child visits are scheduled during normal business hours Monday through Friday. Saturdays and Sundays are reserved for sick visits; however, during the summer months we have a limited number of weekend checkups. If your child is sick, he or she can be seen on a walk-in basis between the hours of 8:00 A.M. – 12:30 P.M. and 2 P.M. -5 P.M., Monday – Friday. Additionally, for your convenience, our Ridgefield location is open for sick visits Saturday & Sunday from 8 A.M. – 12 P.M.

TIPS FOR SCHEDULING WELL CHILD APPOINTMENTS

Remember to make your well child visit appointment as far in advance as possible. Usually 4-6 weeks is needed to schedule a routine visit. Most parents will schedule their child's next visit after their appointment, before leaving our office.

Please try to anticipate school, nursery, camp, daycare and sports physicals and schedule these well in advance. Remember, everyone starts school in the fall so summer physicals are numerous.

When calling our office to schedule an appointment for a well child visit, please call the office at which you wish to be seen.

PHONE CALLS DURING BUSINESS HOURS

When calling our office to talk with one of our doctors, please leave your child's name, age and nature of the call. Also, please leave another phone number where you can be reached later in the day. Our calls during the day for routine care are numerous and will sometimes not be able to be returned until later in the afternoon. If your call is an emergency, please tell our staff and they will arrange for you to speak with us immediately.

PHONE CALLS AFTER BUSINESS HOURS

If it is necessary to call after regular office hours, you can reach our after hours answering service by dialing our regular phone number. Please tell the operator your child's name, date of birth, a brief description of the problem along with your phone number. This message will be relayed to a nurse who will be happy to answer your questions and address your concerns. One of our doctors is always on call and available if necessary. Please reserve requests for prescription refills, discussions of routine behavior, and/or chronic problems to our regular office hours.

EMERGENCIES

During the first two months of life, you should call us for:
- Any fever (rectal) above 100.4° F
- Persistent vomiting
- Refusal of several feedings
- Persistent diarrhea
- Listlessness or unresponsiveness
- Persistent coughing, difficulty breathing
- Sudden onset of unusual rash

In the event of a life-threatening emergency or a serious accident, always ca11 911 or take your child to the nearest emergency room. If possible, have someone notify the office before leaving for the hospital.

OTHER EXAMPLES OF EMERGENCIES

- Possible ingestion of toxic substances
- Sudden onset of difficulty of breathing
- Injury resulting in loss of consciousness, significant bleeding, suspicion of fracture, lacerations, or damage to eye
- Seizure or convulsion

EMERGENCY NUMBERS

Poison Control: 828-9123 or 1-800-222-1222
Rescue Squad: 911
Patterson Office: 282-9706 (normal hours and after hours)
Ridgefield Office: 754-3776 (normal hours and after hours)
Sommerville Office: 379-5437 (normal hours and after hours)
Lactation Nurse: 762-6001

BUSINESS OFFICE & INSURANCE POLICIES

Business office hours are from 10 A.M. until 4 P.M., Monday through Friday. The office policy is that payment in full is expected at the time of each visit by cash, check, or credit card. We accept Visa, MasterCard and American Express. If full payment is not possible, our business office will extend a payment plan to those patients who make arrangements in advance.

Our office participates with many HMO's and PPO's as well as many other insurance plans. We require a copy of your insurance card, including the insurance company filing address, at your first visit. If your managed care plan includes a co-payment or deductible for your office visit, please remember that these payments are due at the time of service.

Please keep us informed of changes in home address, telephone number, and insurance status so that we may serve you more efficiently.

We ask that you review your particular insurance plan so that you are familiar with its various requirements such as co-payments, deductibles, referrals from our doctors for specialist care, emergency room visits, and restrictions on using our in-office laboratory services versus outside laboratory services. We attempt to keep abreast of each plan's requirements and try to advise you of restrictions. However, remember that you are the owner of the policy and you are ultimately responsible for knowing the structure of your plan.

We participate with:

- Southern Health/Coventry Health
- Anthem (BCBS) and Anthem Healthkeepers
- United Health Care/MAMSI
- Optima
- Cigna PPO & HMO
- Aetna US Health Care PPO & HMO
- VHN/Beech Street
- Private Health Care System/Multiplan
- Preferred Care of Richmond

There may be other plans that we now participate with that are not shown here in this booklet. For a complete list of plans, or if you have any questions concerning your insurance, referrals, or your account, please call our business office at (804)754-7422 between 10:00 A.M. – 4:00 P.M., Monday through Friday.

At your first visit, be sure to ask the front desk to sign you up for our patient portal. Once you have signed up, you will be able to access the portal for records, appointment requests, and much more. If you have multiple children, you can sign them all up under the same portal account for easier access.

SCHEDULE OF ROUTINE WELL CHILD VISITS & IMMUNIZATIONS

The following is a suggested schedule of check-up visits and immunizations for your child based on the recommendations of the American Academy of Pediatrics.

We feel as a group that this schedule enables us to follow your child's growth and development and allows adequate scheduling opportunities for routine immunizations and lab work. Additionally, we feel that this gives us the essential time necessary to offer anticipatory guidance concerning behavior, feeding and developmental progress.

Birth	Hep B
Post discharge	1-3 days, may include lactation visit

2 Weeks	Weight check
1 Month	Weight check
2 Months	DTaP, IPV, HIB, Prevnar, Hep B, Rotavirus
4 Months	DTaP, IPV, HIB, Prevnar, Rotavirus
6 Months	DTaP, HIB, IPV, Prevnar, Rotavirus
9 Months	Hep B
12 Months	Varicella, MMR, Hep A, CBC, Lead
15 Months	DTaP, HIB, IPV, Prevnar
18 Months	Check up
2 Years	Hep A, Hematocrit, Lead
3 Years	Urinalysis
4 Years	DTaP, IPV, MMR, Varicella
5 Years	Hematocrit, Lead, Urinalysis
6 – 10 Years	Annual Check-up
11-12 Years	Tdap
11+ years	Meningococcal/ACWY, HPV
12 – 17 Years	Annual Check-up
16+	Meningococcal Group B
18+ Years	Meningococcal/ACWY, Tdap

Hep B	Hepatitis B
DTaP	Diptheria, Tetanus, Acellular Pertussis
IPV	Inactivated Polio
HIB	Haemophilus influenza type B
Prevnar	Pneumococcus
Varicella	Chicken Pox
Hep A	Hepatitis A
PPD	Tuberculosis Screen
MMR	Measles, Mumps, German Measles
TdaP	Tetanus, Diptheria,Acellular Pertussis
HPV	Human Papilloma Virus

If for some reason your child should miss immunizations due to illness or other circumstances, these may be given at each office Tuesday through Thursday, 9 A.M. - 11:30 A.M. and 1:30 P.M. - 4:30 P.M. To arrange for make-up immunizations, you must call the

respective office lab to schedule a time. This is not done on a walk-in basis.

NEWBORN CARE

We have included a few special sections in our booklet by Dr. Barton D. Schmitt. Dr. Schmitt is well known for his anticipatory guidance outlines and is Director of General of Consultative Services, The Children's Hospital of Denver and Professor of Pediatrics, University of Colorado School of Medicine. He is also a member of The Editorial Board of Contemporary Pediatrics.

CHARACTERISTICS OF NEWBORN BABIES

The list that follows describes some common physical characteristics of newborn babies. Most are temporary; a few are congenital defects that are harmless but permanent. Call our office if you have questions about your baby's appearance that this list does not address.

Fontanel. This "soft spot" is found in the top front part of the skull. It is diamond-shaped and covered by a thick, fibrous layer of tissue. It usually pulsates with each beat of the heart. It is safe to touch this area. The purpose of the fontanel is to allow rapid growth of the brain. It normally closes over with bone when your baby is between 9 and 18 months of age.

Molding of the head. Molding refers to the long, narrow, cone-shaped head that results from passage through a tight birth canal. This compression can temporarily hide the fontanel. The head returns to a normal shape in a few days.

Caput Succedaneum. This swelling on top of the head or throughout the scalp is caused by fluid that is squeezed into the scalp during birth. Caput is present at birth and clears in a few days.

Cephalohematoma. This is a lump on the head, usually confined to one side, which occurs when blood collects on the outer surface of the skull under the skin. It is caused by friction between

the infant's skull and the mother's pelvic bones during birth. It first appears on the second day of life and may grow larger for up to five days. It doesn't disappear completely until the baby is 2 or 3 months of age, though it may take longer in some cases.

Scalp hair. Most hair is dark at birth. This hair is temporary and begins to fall out by 1 month of age. Some babies lose it gradually while the permanent hair is coming in. Others lose it rapidly and temporarily become bald. The permanent hair generally appears by 6 months. It may be an entirely different color from the newborn hair.

Lanugo (body hair). Lanugo is the fine, downy hair that is sometimes present on the back and shoulders of newborn babies. It is more common in premature infants. It rubs off with normal friction by 2 to 4 weeks of age.

Folded ears. The ears of newborns are commonly soft and floppy. Sometimes the edge of one is folded over. The ear will assume its normal shape as the cartilage becomes firmer over the first few weeks of life.

Ear pits. About 1% of normal children have a small pit or dimple in front of the ear, below the temple. This minor congenital defect is not a problem unless it becomes infected.

Swollen eyelids. Your baby's eyes may be puffy because of pressure on the face during delivery.

Hemorrhage on the eye. Some babies have a flame-shaped hemorrhage on the white of the eye. It is caused by breaking of blood vessels on the surface of the eye during birth and is harmless. The blood is reabsorbed in two to three weeks.

Eye color. The permanent color of the eyes, usually blue, green, gray, brown, or some variation of these colors, is often uncertain until your baby reaches 6 months of age. Caucasian babies are usually born with blue-gray eyes. African American babies are usually born with brown-gray eyes. Children who will have dark eyes often change to the permanent eye color by 2 months of age. Children who will have light-colored eyes usually change by 5 or 6 months of age.

Flattened nose. The nose may be flattened or pushed to one side during birth. It will look normal by 1 week of age.

Sucking callus or blister. A sucking callus occurs in the center of the upper lip from constant friction at this point during bottle- or breast-feeding. It will disappear when your child begins cup feedings. If the baby sucks his thumb or wrist, a callus may develop there too.

Tongue-tie. The tongue in newborns normally has a short, tight band on the underside that connects it to the floor of the mouth. This band usually stretches with time, movement, and growth. Tongue-tie, or tight tongue, is a rare condition in which the band keeps the tip of the tongue from protruding beyond the teeth or gum line. Tongue-tie doesn't usually cause any symptoms, nor does it interfere with speech development.

Blocked tear duct. If your baby's eye waters continuously, he may have a blocked tear duct. This means that the channel that normally carries tears from the eye to the nose is blocked. It is a common condition, and more than 90% of blocked tear ducts open up by the time the child is 12 months old.

Epithelial pearls. There may be little cysts containing clear fluid or shallow white ulcers along the gum line or on the roof of the mouth. They result from the blockage of normal mucous glands. They disappear after one or two months.

Teeth. The presence of a tooth at birth is rare. About 10% are extra teeth without a root structure. The other 90% are prematurely erupted normal teeth. The distinction between the two can be made with an X-ray. A dentist needs to remove extra teeth only if they become loose, because of the danger of choking, or if they cause sores on your baby's tongue.

Swollen breasts. Many babies, both male and female, develop swollen breasts during the first week of life. The swelling is caused by the passage of female hormones from the mother across the placenta during pregnancy. It generally persists for four to six months but may last longer in breastfed and female babies. Swelling may go down in one breast a month or more before the other breast. Never squeeze the breast because this can cause infection. Be sure

to call our office if a swollen breast develops signs of infection such as general redness, red streaks, or tenderness.

Female genitals. Swollen labia. The labia minora may be quite swollen in newborn girls because of the passage of female hormones across the placenta. The swelling will go down in two to four weeks.

Hymenal tags. The hymen also may be swollen because of maternal hormones and may have smooth, ½ inch projections of pink tissue called tags. These tags are harmless. They occur in 10% of newborn girls and slowly shrink over two to four weeks.

Vaginal discharge. A clear or white discharge may flow from the vagina during the latter part of the first week of life as maternal hormones in the baby's blood decline. Occasionally the discharge will become pink or blood-tinged (false menstruation). This normal discharge should not recur once it stops.

Male genital. Hydrocele. The scrotum of newborn boys may be filled with clear fluid that has been squeezed into the scrotum during birth. This common, painless collection of fluid is called a hydrocele. A hydrocele may take 6 to 12 months to clear completely. It is harmless but should be checked during regular visits to the doctor. If the swelling changes size frequently, a hernia may also be present, and you should call our office during regular hours to speak with a physician.

Undescended testicle. The testicle is not in the scrotum in about 4% of full-term newborn boys. Many of these testicles gradually descend into the normal position during the following months. In 1-year-old boys, only 0.7% of all testicles are undescended and need to be brought down surgically.

Tight foreskin. Most uncircumcised infant boys have a tight foreskin that doesn't allow you to see the head of the penis. This is normal, and the foreskin should not be retracted. The foreskin separates from the head of the penis naturally by 5 to 10 years of age.

Erections. Erections occur commonly in newborn boys, as they do at all ages. They are usually triggered by a full bladder and demonstrate that the nerves to the penis are normal.

Feet turned up, in, or out. Feet may be turned in any direction inside the cramped quarters of the womb. As long as your child's feet are flexible and can be moved easily to normal position, they are normal.

Long second toe. The second toe is longer than the great toe as a result of heredity in some ethnic groups, especially those that originated around the Mediterranean Sea.

"Ingrown" toenails. Many newborns have soft nails that bend and curve easily. The nails are not truly ingrown, however, because they don't curve into the flesh or cause irritation.

Tight hips. When we examine your child, we will spread the legs apart to make sure the hips are not too tight. Outward bending of the upper legs until the knees touch the surface the baby is lying on is called "90° of spread." (Less than 50% of normal newborn hips can be spread this far). As long as the upper legs can be bent outward to 60° and both hips are equally flexible, they are fine. The most common cause of a tight hip is a dislocation.

Tibial torsion. The lower leg bones (tibias) normally curve inward in newborns because the baby was confined to a cross-legged position in the womb. If you stand your baby up, you will also notice that the legs are bowed, and the feet are pigeon-teed. Both of these curves are normal and will straighten out after your child has been walking for 6 to 12 months.

BEHAVIOR

Some things in newborn babies commonly do concern parents, but they are not signs of illness. Most are harmless reflexes caused by an immature nervous system and disappear in 2 or 3 months. They include:

- Chin trembling
- Lower lip quivering
- Frequent yawning
- Hiccups
- Passing gas
- Noises caused by breathing or movement during sleep

- Sneezing
- Spitting up (small amounts) or belching
- Startle reflex - a brief stiffening of the body in response to noise or movement (also called the Moro reflex or embrace reflex)
- Straining with bowel movements
- Throat clearing or gurgling sounds caused by secretions in the throat. These are not cause for concern unless your baby is having labored breathing.
- Irregular breathing. An irregular breathing pattern is not cause for concerns as long as your baby is content, his breathing rate is less than 60 breaths per minute, pauses between breaths last less than six seconds, and he doesn't turn blue. Occasionally, infants take rapid, progressively deeper breaths to completely expand the lungs.
- Trembling or jitteriness of arms and legs during crying. Jitters are common in young infants and parents sometimes worry that their baby is having a convulsion. Seizures are rare, however. During seizures babies typically make rhythmic jerking movements, blink their eyes, suck rhythmically with their mouths, and don't cry. If you are concerned your baby may be having a seizure, call our office immediately.

TIPS FOR NEW MOTHERS

For most mothers, the first weeks at home with a new baby are the hardest of their lives. You will probably feel overworked, even overwhelmed and inadequate sleep will leave you fatigued. Caring for a baby can be a lonely, stressful responsibility. You may wonder if you will ever catch up on your rest or work. The solution is to ask for help. No one should be expected to care for a young baby alone.

PREVENTING EXHAUSTION

Every young baby awakens one or more times each night. The way to avoid sleep deprivation is to know the total amount of sleep you need each day and to get that sleep in bits and pieces. Go to bed earlier in the evening. When your baby naps, you must also need to nap.

If you still are not getting enough sleep, hire a babysitter or bring in a relative to help out. If you don't take care of yourself, it is harder to take care of your baby.

THE POSTPARTUM BLUES

More than 50% of women experience postpartum "blues" which can start as soon as the third or fourth day after delivery. The symptoms include tearfulness, tiredness, sadness, and difficulty thinking clearly. The main cause of this temporary reaction is probably the sudden decrease of maternal hormones after delivery. Since the symptoms commonly begin on the day the mother comes home from the hospital, the full impact of being totally responsible for a dependent newborn may also be a contributing factor. Many mothers feel let down and guilty about the symptoms because they have been led to believe they should be overjoyed about caring for their baby. There are several ways to cope with the postpartum blues:

- Acknowledge your feelings. Discuss them with your husband or partner. If you are feeling trapped and overwhelmed by your seemingly insurmountable new responsibilities, discuss that too. Don't try to suppress crying or put on a "super mom" show for everyone.
- Get adequate rest.
- Get help with your work.
- Mix with other people. Don't let yourself become isolated. Go out of the house at least once every week - go to the hairdresser, go

shopping, go to the gym, visit a friend, or see a movie. By the third week, consider setting aside an evening each week for a "date" with your significant other.
- If you don't feel better by the time your baby is 1 month old, talk to your physician about the possibility of counseling or medication for depression.

HELPERS: RELATIVES, FRIENDS, SITTERS

Remember, everyone needs extra help during the first few weeks alone with a new baby. Ideally, you should be able to plan for help before your baby is born. The best person to help is usually your mother or mother-in-law. If not, ask other relatives or friends to help out or hire a teenager or adult, perhaps someone from a local high school or college, to come in several times a week to help with housework or look after your baby while you go out or get a nap. If you have other young children, you absolutely will need daily help. Make it clear to helpers that your role is to look after your baby. The helper's role is to shop, cook, clean, and wash clothes and dishes. If your baby has a medical problem that requires special care, ask our office about how to arrange home visits by a community health nurse. We recommend that any additional caregiver have an up to date Tdap vaccine prior to being around the new baby.

VISITORS

Only close friends and relatives should visit you during your first month at home. They should not visit if they are sick. Friends who don't have children may not understand your needs. To prevent unannounced visitors, you can put a sign on the front door that says "Mother and baby sleeping. No visitors. Please call first." If you have other children, encourage visitors to pay special attention to them as well as the baby. It helps to have a stash of small toys, stickers, coloring books, etc, that visitors can "gift" to your older children, helping them feel as though the visitors want to see them too, not just the new baby.

FEEDING YOUR BABY: WEIGHT GAIN

Your main assignments during the early months are loving and feeding your baby. All babies lose a few ounces during the first few days after birth. However, they should never lose more than 10% of their birth weight (usually about 8 oz.). Most breast-fed and bottle-fed babies don't lose any weight after day four and are back to birth weight by 10 days of age. Then infants gain approximately 1 ounce per day during the first 4 months. If milk is provided liberally, the normal newborn's hunger drive insures appropriate weight gain.

A breastfeeding mother often wonders if her baby is getting enough calories since she can't see how many ounces the baby takes. Your baby is doing fine if he appears satisfied after feedings, takes both breasts at each nursing, and wets six or more diapers each day.

Whenever you are worried about your baby's weight gain, bring him to our office for a weight check. Feeding problems detected early are much easier to remedy than longstanding ones. A special weight check one week after birth is a good idea for infants of a first-time breastfeeding mother or a mother concerned about her milk supply.

We have a lactation specialist on staff, Tammy Rockwell, R.N., IBCLC, and she can be reached at 762-6001 or at our Patterson location. She is available Monday thru Friday for appointments. You may also call her for your breastfeeding questions.

DEALING WITH CRYING

All young babies do some unexplained crying (crying not caused by hunger, sickness, or pain). Crying babies need to be held. They need someone with a soothing voice and a soothing touch. Pick up your baby and cuddle and rock him when he cries. You can't spoil a baby with too much holding during the early months of life. Some babies are very sensitive and need an even gentler touch and more

attention. If you think your child is crying because he is sick or in pain or if you need additional help with the crying, call our office.

TAKING BABY OUTDOORS

You can take your baby outdoors at any age. You already took him outside when you left the hospital, and you will be going outside again when you go for his two-week check-up. Dress the baby in as many layers of clothing as an adult would wear for the outdoor temperature. A common mistake is overdressing babies in the summer. In the winter, babies need a hat to protect against heat loss because most body heat is lost through the head. Cold air or winds do not cause ear infections or pneumonia, however.

Babies' skin is thinner and more sensitive to the sun than the skin of older children. Keep sun exposure to small amounts (10 to 15 minutes at a time). Protect your baby's skin from sunburn with a bonnet and clothing that covers most of his body. Most sunscreens can be used at any age but avoid using those that contain p-amino benzoic acid, or PABA, until your baby is six months old.

You should probably avoid camping and crowds during your baby's first month of life. Also, try to avoid close contact with people who have infectious illnesses.

After a couple of weeks at home, it is all right to take your infant outside during reasonable weather. Infants rarely need to be bundled inside or outside. Whatever the weather dictates that you should wear is probably appropriate for your infant. Remember, if you are hot or cold outside, there's a good chance your baby is also.

For the first couple of months, it is appropriate to avoid crowds such as in the shopping mall, grocery store, etc. Also, it is wise to avoid certain nurseries, such as the church nursery or workout nursery. These nurseries are large sources of viral particles, which are easily conveyed by touch and unnecessarily expose your infant. Those people who handle your baby should frequently wash their hands, since it is by hand to nose or mouth transmissions that most of our colds or viruses are passed

THE TWO-WEEK MEDICAL CHECK-UP

This check-up is probably the most important medical visit during your baby's first year. By two weeks of age, babies usually have developed symptoms of any physical condition that was not detectable during their hospital stay. By this point too, your child's physician will be able to judge how well he is growing on his from his height, weight, and head circumference. This is also the time your family is under the most stress from adapting to a new baby and may be especially in need of information and support.

Try to develop a habit of jotting down questions about your child's health or behavior. Bring this list with you to office visits. We welcome the opportunity to address your questions and concerns, especially ones that cannot be answered easily by reading or talking with other mothers.

If at all possible, have your husband or partner join you when you bring your baby for check-ups. We prefer to get to know the husband or partner during a routine visit rather than during the crisis of on acute illness. If you think your baby is sick between check-ups, be sure to call our office for help.

FEEDING

BREAST FEEDING

Breast milk provides the ideal nutrition for your baby. In the hospital you will receive instructions and help on how to initiate breastfeeding including the proper latching on technique and positioning.

Shortly after birth most babies will latch on and nurse well. This type of successful feeding, however, may be intermittent over the next few days. It is most important in these first few days to master the proper "latching on" technique and positioning of your

Positioning tips

1. Use different positions to help completely empty each breast.

2. Attempt to align your baby's head, shoulders, and buttocks.
3. Use a pillow to help support your baby to the height of your breast.

Your breasts initially produce colostrum, which is thick high, protein substance rich in nutrients and antibodies. Your milk supply will usually be present beginning approximately 3-5 days after birth. Until your milk supply is well established, and your baby is gaining weight (usually 2 weeks), nurse your infant whenever he cries or seems hungry (demand feeding). After your baby is 1 month of age, and your mild supply is in, babies can receive adequate breast milk by nursing every 2-2.5 hours. Most infants will feed every 2-3 hours; however, some will try to sleep longer. If your baby attempts to sleep longer than 4 hours during the daytime it would be advantageous to wake the baby up so the baby doesn't start to confuse daytime and nighttime schedule. However, if you have nursed your baby around midnight and the baby has slept until 5 A.M., this would be all right.

Most mothers are uncertain of the amount of breast milk their baby is receiving. These are several signs that will help assume you trust your baby is getting enough breast milk.

1. 2-5 stools in 24-hour period during the first 2-6 weeks of life
2. 6-8 wet diapers per day
3. Audible swallowing during feedings
4. Your infant seems satisfied between feedings

The most important factors to ensure an adequate supply of milk are for mothers to get plenty of rest, eat a healthy well-balanced diet and drink plenty of fluids. Contrary to popular belief, it is not necessary to drink milk in order to produce milk. Occasionally, mothers will find certain foods will affect their babies. These are commonly cow's milk, garlic, spicy foods, and caffeine. While mothers are breastfeeding, it is important for them to continue their prescribed prenatal vitamins. Vitamins and fluoride supplementation for your baby will start around 6 months of age.

Also, other medications that were allowed while you were pregnant are also allowed while nursing. If you are unsure about a particular medication (prescription or over-the-counter) please call our office.

Once your breast milk is well established, you may choose to pump or express your breast milk. This milk can be kept in the refrigerator for two to five days or may be frozen for 3-4 months.

BOTTLE FEEDING

Commercially prepared formulas have been shown to be adequate in providing nutrition for growth and development. It is not necessary to have vitamin supplementation for most formula fed babies; however, the AAP recommends Vitamin D supplementation in formula fed babies who are not yet drinking at lease 32 ounces of formula a day, which is most babies under 6-8 months old.

Commercial formulas come in three different preparations: ready to feed, concentrate, and powder. All of these contain the same nutritional value, yet appearances are quite different. This is due to the individual make up of each product and its solubility.

Initially, you will find that babies tend to take about 1-2 oz. of formula. This will usually result in a feeding schedule of about 3-4 hours. As the time between feedings shortens, the baby should be increased to 2-3 oz. of formula. The optimal schedule for feedings should be 3-4 hour intervals and the ultimate volume of formula will usually be 6-7oz. per bottle or 24-32 oz. per day. This volume and schedule will usually take 3-4 weeks to achieve.

Formula may be prepared earlier and kept in the refrigerator for 24 hours. You may warm the formula using a pot of water or a bottle warmer (not a microwave!), however be sure to check the temperature of the formula and nipple prior to feeding.

BURPING, SPITTING UP, AND VOMITING

Spitting up (also called regurgitation or reflux) is the effortless spitting up of one or two mouthfuls of stomach contents.

Formula or breast milk just rolls out of the mouth, often with a burp. Spitting up is harmless as long as your infant doesn't spit up large amounts that interfere with normal weight gain. It results from poor closure of the valve (ring of muscles) at the top of the stomach.

From time to time all infants will have forceful vomiting which is often descried as "projectile." This occurs on an infrequent basis and usually does not indicate that anything is wrong, however, if this type of forceful vomiting occurs frequently, or if the vomitus is green in color, you should inform the doctor.

PACIFIERS, CRYING, FRETTING, AND GASSINESS

In the first few months of life infants will need to suck even though they are not hungry. Pacifiers can serve a very useful purpose during this time. It is much easier to take the pacifier away later on than it is to take away the thumb or fingers if your infant finds these in this early time.

Crying and fretting are very normal behavior for infants to exhibit. Over time you will be able to distinguish exactly what is being inferred. All infants should be attended to initially, however if they have been fed, burped, changed and are seemingly in no apparent physical discomfort, a short period of fretfulness /crying is all right. Some infants will develop a specific time of day during which they are quite fussy. There are as many remedies to fussiness of infants as there are relatives. Usually these episodes are self limiting and survivable. Some helpful techniques include physically walking or driving the infant around or placing the infant securely in a car seat on top of a running dryer for short periods of time (but do not leave him unattended!).

Gassiness is often not only the cause of fussiness /crying, but a result of fussiness/crying. As infants cry they swallow air; the more they cry, the more air is swallowed. Should this fussiness be unmanageable, please discuss it with your doctor.

VITAMINS

The AAP (American Academy of Pediatrics) now recommends vitamin D supplementation for infants who are exclusively breast-fed. This is easily accomplished with an over-the-counter vitamin solution.

SUDDEN INFANT DEATH SYNDROME (SIDS)

The American Academy of Pediatrics (AAP) recommends that all infants sleep on their backs, as it reduces the risk of SIDS by at least 40%. Babies who sleep on their stomachs have a 3-9 times greater risk of SIDS, and side sleeping has twice the risk of SIDS when compared to babies who sleep on their backs.

The following are main things you can do that will significantly lessen your infant's risk of SIDS:

- Firm mattress: soft bedding and pads are associated with increased risk of SIDS. Infant crib mattresses are purposefully firm for this reason and your bed is inherently dangerous, even if you believe you are taking other measures to prevent suffocation.
- Keep soft objects out of the crib: There should be no bumpers, blankets, stuffed animals, pillows or wedges in your baby's crib as this increase the risk of suffocation and SIDS. This includes stuffed animals attached to pacifiers.
- Not Smoking: Having smoke residue in your house is significantly associated with increased risk of SIDS because the chemicals appear to interfere with the infant's brain regulation of breathing.
- Flat Surface: curved and upright surfaces, such as bouncy seats, swings, rock n'plays and car seats should not be used for unobserved sleep. These positioning devices are also associated with increased risk of SIDS.

  For more information, you can go to the AAP.org website and follow this link https://www.aap.org/en-us/advocacy-and-

policy/aap-health-initiatives/healthy-child-care/Pages/Safe-Sleep.aspx

BOWEL MOVEMENTS AND CONSTIPATION

During your stay in the hospital and after the first few days home, your infant's stools may be thick and dark green. This stool is called meconium. These will change fairly quickly to a loose yellow seedy stool for both breast-fed and bottle-fed infants. Breast-fed infants possibly can stool each time they are fed, whereas bottle-fed infants may stool around 3-4 times a day. The color and frequency of stools are generally not important; however, if your child has white or light grey stools in the first month of life, please immediately bring it to the attention of your doctor. Over time both breast-fed and bottle-fed infants may experience a time period of a couple of days without a bowel movement. The stool consistency at this time may be soft, runny, pasty or clay-like, and your infant may strain and turn red attempting to pass this stool. This is completely normal and does not constitute constipation. Constipation refers to the consistency of the stool and the infrequency of the bowel movement. A constipated stool would be a hard "pellet-like" stool. Please contact your doctor if you are concerned your child may have significant constipation.

UMBILICAL CORD CARE AND GENITAL CARE

The cord usually remains attached firmly for 2-3 weeks. It may fall off sooner (which is all right), but most are attached well after the 2-week visit.

During the time the cord is attached you may see a slight amount of bleeding and brown mucous formation, both of which are normal. It is important not to place your infant in water for a bath until the cord has fallen off. If you notice the area of skin surrounding the cord has become red, streaked, or has pimples or blisters, please contact your doctor.

If your child has been circumcised, this procedure has usually been done on the second or third day of life by your obstetrician. The foreskin has been removed and the tip area of the penis is swollen and red. Over the next 4-5 days it will be important to change the dressing (gauze pad) and Vaseline with each diaper change. This will be reviewed with you before discharge. After five days you may continue using Vaseline with each diaper change until we see you at the 2-week visit.

For uncircumcised male infants, gently pull back the foreskin and wash the area with a warm washcloth. Remember, the foreskin of an uncircumcised male infant may not be fully retractable until 5-6 years of age.

For female infants, gently separate the labial area and clean with a washcloth. There is often a white discharge or even slightly bloody mucous seen in this area. These are due to maternal hormones during pregnancy and are of no concern.

SKIN CARE, BATHING AND DIAPER AREA

Your infant's bath should be a pleasant procedure, as most infants enjoy getting their clothes off and kicking a little while before the bath. Until the umbilical cord has fallen off, infants can be given a sponge bath with mild soap fragrance free soap and water. After the cord has fallen off, regular baths in a baby tub, kitchen sink or bathinette are all right. In washing your infant, most attention should be given to the hands, feet and bottom. Washing does not need to be done every day, even once weekly is acceptable in your infants. All infants will have an increased amount of dry skin, scaling and peeling. When this occurs on the scalp the best thing to do is to brush with a soft brush and avoid oils or lotions on the scalp. Similarly, your infant may have a scattered red, white pimply rash over the face, scalp neck, cheeks, shoulders and upper back. This rash is called milia and will persist for 1-3 months intermittently resolving. There is nothing that will improve this rash, however using face oils or lotions may actually make it worse. The best way to wash the face is with warm water. The rash will not leave any scaring and

looks worse after the baby lays on a particular side for feedings. As for the peeling and scaling on the rest of the body, it is all right to use lotions on these areas.

COUGHING, SNEEZING AND NASAL CONGESTION

Infants are predominately nose breathers. Therefore, regardless of the season, they tend to create thicker mucus. This usually occurs more in the evening hours or early morning. This thickened mucus causes the defensive techniques of sneezing and coughing to occur. These are done in an effort to clear the nasal passage and throat and are not indicative of a cold or allergy. Most infants can be helped with this thick mucus by these suggestions:

- Use a nasal aspirator (blue bulb) if mucus can be reached or aspirated, if not then
- Add a few drops of saline solution to help loosen the mucus and allow it to be suctioned out. Sometimes just using the saline nose drops may be just as beneficial.

Saline nose drops can be purchased over the counter. At this age we try to avoid any of the over-the-counter decongestant agents.

EYES, TEAR DUCTS AND MUCUS

In the first few months of life, infants often appear to be cross-eyed or unable to fixate on an object at a distance. Also, you may notice an increased amount of tearing or a yellow-greenish mucus build up in the morning. This is the result of a blocked tear duct. The tear duct in the corner of the eye nearest the nose allows tears to flow from the eye into the nose, however if this is blocked the mucus builds up and results in the condition described above. To relieve this, you can use a warm washcloth and clean out the eyes as often as necessary. Also, by massaging toward the corner of the eye /tear duct several times a day, you can help loosen the mucus and improve the drainage.

JAUNDICE

Most infants will appear slightly yellow or jaundiced by the second to fourth day of life. This is due to a build up of bilirubin in the infant's tissue and blood. Bilirubin is the pigment of red blood cells, and in older infants, children and adults, this pigment is broken down in the liver, so it can be passed out of the body by the kidneys in the urine. However, in the 2-4 day old infant, the liver is not functioning up to full capacity. Therefore, bilirubin is transferred to the skin, so sunlight can change it to the form, which can be excreted by the kidneys. This is what gives infants the yellowish hue to the skin and sometimes to the white part (sclera) of the eyes.

Usually jaundice is longer lasting in breast-fed infants than in formula-fed infants. The jaundice coloration of the skin usually resolves in 7-10 days. This process is normal in most cases and can be helped along by allowing your infant to be exposed to daylight (not direct sunlight) in a well-heated room of your house. As feedings pick up and stools become more frequent, yellow and seedy this also results in a decrease in bilirubin. However, if your infant seems to be increasingly yellow with decreasing stools or is more lethargic after 3-5 days, please contact your doctor.

CLOTHING AND GOING OUTSIDE THE HOME

After a couple of weeks at home it is all right to take your infant outside during reasonable weather. Infants rarely need to be bundled inside or outside. Whatever the weather dictates that you should wear is probably appropriate for your infant. Remember if you are hot or cold outside, there's a good chance your baby is also.

For the first few months is it appropriate to avoid crowds such as in the shopping mall, grocery store, etc. Also, it is wise to avoid certain nurseries such as the church nursery or workout nursery. These nurseries are large sources of viral particles, which are easily conveyed by touch and unnecessarily expose your infant. Those people who handle your baby should frequently wash their

hands, since it is by hand to nose or mouth transmissions that most of our colds or viruses are passed.

NEWBORN AND CHILDHOOD DEVELOPEMENT

DEVELOPMENT & TOYS

0-6 months: Sensori-Motor Period. Play involves auditory and visual toys. Hand use is random and involves batting and transferring from, one hand to the other. At the end of this period more controlled grasp occurs.
6-8 months: Playtime is geared to baby's mouthing, banging, and beginning understanding of cause and effect.
8-12 months: The age of exploration. Toy use incorporates deliberate release of grasp, horizontal pull, busy box type activity centers, tool use, cause effect, and object permanence.

Books: Books cross all developmental stages and play a big role in a child's cognitive and language development. Early in life, brightly colored books displaying patterns may be used for tracking and touching. When children are 8-12 months, books displaying photographs with cardboard pages for used turning are excellent, as well as clear, colorful pictures displayed as one item per page.

1-2 years: The Active Period. Toy use involves large muscle movement, refined grasp to manipulate toys using fingers, prewriting, and sound production and labeling skills for speech and language development.
2-5 years: The Preschool Years. Toys have to do with pre-academic skills (sorting by shape and size, picture matching and puzzles), imagination, and socialization.

DEVELOPMENTAL MILESTONES

Listed below are age appropriate speech/ language and motor skills. Your child should be demonstrating those skills that coincide with their specific age level.

Three Months

- Startles and/or cries to loud noises
- Listens to sounds and voices
- Uses different cries for hunger, pain, etc.
- Coos and gurgles
- Smiles
- Hands are open frequently
- Momentarily supports head while holding upright

Three to Six Months

- Responds to noise and voices by turning head
- Squeals and laughs
- Begins to babble (i.e., repeats series of vowel and consonant sounds)
- Plays by making sounds and noises while alone or with others
- Sits supported for short period of time
- Begins to see small objects
- Touches hands together

Six to Nine Months

- Responds to own name
- Understands gestures (i.e., outstretched arms)
- Begins to imitate motions (i.e., waving, shaking)
- Stops activity in response to "no"
- Mimics the sounds and number of syllables used by others
- Begins to look up for sounds
- Begins to support weight with arms while on stomach
- Begins to bear weight on legs while holding upright
- Begins to scoot and hold bottle

Nine to Twelve Months

- Begins to understand simple requests accompanied by gesture
- Begins to understand the names of familiar people/objects
- Attempts to imitate words and/ or begin to say first words
- Uses jargon (babbling with intonation that sounds like speech)
- Begins to crawl, attempts to pull up and cruise around furniture
- Begins to localize sound by turning head

Twelve to Eighteen Months

- Understands simple commands, sentences, and questions (i.e., "Where's Momma?" "Give me your cup.")
- Points to a few body parts
- Begins to point to named pictures in books
- Uses a few single words meaningfully
- Uses a few words along with jargon
- Speech is 25% intelligible
- Begins to walk well without support
- Begins to feed self and take off shoes

Eighteen to Twenty-Four Months

- Listens to familiar stories
- Begins putting 2-3 words together (i.e., "Eat Cookie." "Daddy bye-bye car.")
- Names most common objects and pictures
- Speech is 50-70% intelligible
- Attempts to tell about experiences using a combination of jargon and some true words
- Begins to run, looks at books (pictures)
- Begins to undress

Two to Two and One-Half Years

- Understands action words
- Understands prepositions such as "in" or "on"
- Follows two-part directions ("Go get your shoes and sit on the couch.")
- Has a vocabulary of approximately 50 words, understands approximately 500 words

- Refers to self by name
- Uses three word sentences

Two and One-Half to Three Years

- Understands more complex sentences
- Uses pronouns frequently
- Uses verbs ending with "-ing"
- Uses some "wh" questions (who, when, where, what)
- Sentence length is 3-4 words
- Has around 300 words in speaking vocabulary
- Begins to throw ball overhand
- Begins to answer simple questions
- Begins to know his or her sex

Three to Four Years

- Understands references to past and future events
- Understands and uses "wh" questions
- Uses past tense verbs (went, walked)
- Asks "why" questions
- Uses complete sentences most of the time
- Vocabulary approximately 1500 words
- Uses 4-5 word sentences
- Speech is 75-100% intelligible
- Begins to play games (hide & seek, cops & robbers, etc.)
- Names pictures in books
- Tells action taking place in pictures
- May have imaginary companion(s)

If you have any questions, or if your child is not demonstrating those skills that coincide with the child's age level, speak with your pediatrician.

COMMON PEDIATRIC CONCERNS

FEVER

Normal body temperature is generally around 98°-100°F. Fever is usually referred to as temperature elevation above 100.4°F. Though fever is usually a major concern with parents, it does not need to be met with panic in children over 2 months old. Fever tends

to make children somewhat more lethargic, cranky and more clingy than usual. Once the fever comes down, children tend to return to their normal activities. While fever should alert you that your child is ill, it is rarely a cause for alarm, since the degree of elevation of temperature is not a reliable indication for the seriousness of the illness.

Measuring temperature accurately is most important. There are now several advances in thermometers, which include digital read out, fever strips and ear thermometers. While all of those methods certainly are convenient, some require (ear thermometer) a skilled approach to ensure accuracy. In younger children it is best not to use the ear thermometer. For infants, if is best to measure temperature rectally); toddlers are best measured by axillary methods and older children by oral or ear thermometer.

The body produces fever in a normal response to illness or infections. Additionally, fever has been found to help our immune system work and hinder progression of infections. The best way to determine whether or not to treat a fever, is if your child is experiencing significant.

There are some common myths regarding fever we would like to put to rest:

- Myth: Fevers can cause brain damage or fevers can be dangerous.
- Fact: Fevers from infection don't cause brain damage. Brain damage can only occur when the body's temperature rises above 108°F due to environmental temperatures (ie: being left in a hot car)

- Myth: Anyone can have a febrile seizure
- Fact: Only 4% of children have febrile seizures. Additionally, febrile seizures are not harmful and almost always stop on their own in less than 5 minutes.

- Myth: With medicine, fevers should come down to normal
- Fact: Fevers often come down 2-3 degrees with medicine such as Tylenol (acetaminophen) or Motrin (ibuprofen).

- Myth: Once the fever comes down, it should not come back.
- Fact: Fevers will often come back when the medication wears off and that can occur for 3-5 days in a row.

- Myth: Temperatures between 98.7°F and 100°F are "low grade"
- Fact: The body's normal temperature changes throughout the day and peaks in the late afternoon and early evening. Even if you believe your child's normal body temperature is in the 97°F range, a temperature of 99°F does not indicate fever. It is worth noting that the absence of fever does not mean your child is not ill as not all children get fevers with all illnesses.

Parents often wonder when to inform the doctor about fever. Our practice feels that if your child is 2 months of age or younger and has a temperature above 100.4°F, that you should inform your doctor immediately. For older children, a temperature above 102° F for more than 24-48 hours deserves to be discussed with your doctor.

TREATMENT OF FEVER

1. Allow the child to drink plenty of fluids.
2. You may bathe the child in a warm bath, but since fevers are not dangerous, you do not need to use a cool bath to bring your child's temperature down.
3. Do not sponge with alcohol. This will also cause chills and may lower temperature too quickly.
4. You do not need to prevent your kids from cuddling under a blanket when they have chills with fever. The chills are there as the body attempts to raise its temperature and the faster they warm up, the faster the chills will improve.

5. Medication - never use aspirin in children. Acetaminophen (Tylenol) may be used for all children. If your child is under 2 months of age, please contact your doctor prior to using Acetaminophen (Tylenol). Motrin/Advil (Ibuprofen) should only be used in kids over 6 months of age.

DOSAGE FOR ACETOMINOPHEN (Tylenol)

For your convenience, a chart containing dosage information for acetaminophen has been inserted below. This chart, as well as others, are available and are updated on the Tylenol website. Please visit this website at www.Tylenol.com. This chart is only a guide! If you have any questions when using this guide, please call our office to speak with one of our providers.

Children's & Junior Strength Tylenol/Acetaminophen		Suspension Liquid & Original Elixir	Chewable Tablets	Junior Strength
Age	Weight (lbs)	160 mg/ 5 mL	80 mg tabs	160 mg each
0-3 mos	6-11	1.25 ml	Not recommended	Not recommended
4-11 mos	12-17	½ tsp. or 2.5 mL	Not recommended	Not recommended
12-23 mos	18-23	¾ tsp. or 3.75 mL	Not recommended	Not recommended
2-3 yrs	24-35	1 tsp. or 5 mL	2 tablets	Not recommended
4-5 yrs	36-47	1 ½ tsp. or 7.5 mL	3 tablets	Not recommended
6-8 yrs	48-59	2 tsp. or 10 mL	4 tablets	2 tablets
9-10 yrs	60-71	2 ½ tsp. or 12.5 mL	5 tablets	2 ½ tablets
11 yrs	72-95	3 tsp. or 15 mL	6 tablets	3 tablets
12-14 yrs	96	Not recommended	Not recommended	4 tablets

COMMON COLDS, COUGH AND CONGESTION

In this day and age, often both parents are working, daycare or some kind of baby sitter arrangements, are sometimes necessary. It follows that with an increasing exposure to children in the early

years of life; there will be an increasing number of illnesses. Most children will have between 5-9 colds each year in their first few years. These colds are due to viruses and are passed quite easily from hands to mouths or noses. Each cold may last up to 10-14 days depending on the particular virus. Each sitter's house, daycare or nursery may have more than one particular type of virus. Symptoms usually are runny nose, congestion, sneezing, and cough. Some children may have a fever from a cold. Fever from a cold typically occurs at the beginning of the illness, within a day or two of when the symptoms first start. Fevers that develop after your child has already been ill for 4-5 days should be evaluated by one of our providers.

SORE THROAT

Many children experience sore throat, but they often do not complain about their throats. These children often have decreased appetite and refuse to drink or even swallow at times. They will refer to sore throat pain as "my mouth hurts," "my neck hurts," or "my tongue hurts." Sore throats, however, are mostly associated with viral infection or irritation from allergies in the spring, or chlorine in the summer. Most of these viral infections also have symptoms of fever, stomachache, headache and swollen glands. These symptoms are also exhibited with streptococcal (strep throat) infections. Strep infections require antibiotic treatment to improve, whereas viral infections will not respond to antibiotics and symptoms may last for up to 10 days. The best way to distinguish between these similar presenting illnesses is by obtaining a strep test and maybe a culture. This culture requires 48-72 hours to complete and is quite accurate.

In general, treatment of sore throats is best accomplished by using Acetaminophen or Ibuprofen for fever and pain relief and using cold liquids (Hi-C, Kool-Aid, Gatorade, etc.), Popsicles or ice cream to soothe the throat.

For older children mouth ulcers, such as those caused by hand, foot, mouth disease, can be soothed by using a combination of

Benadryl Allergy and Maalox antacid (mix these in equal parts based on the appropriate Benadryl dose for age). Allow the child to swish this mixture around in their mouth, gargle and spit out. This can be done as needed.

EARACHE

Ear pain is a common problem of childhood. Usually it is confined to two particular problems: external otitis (swimmer's ear), and middle ear infection.

Swimmer's ear usually occurs in the summer months however, it may occur year-round. It is due to the collection of water in the ear canal. This water causes local irritation to the skin surface of the ear canal and thereby allows infection to occur in the skin of the ear canal. This small area of infection and inflammation results in a great deal of pain. Children usually complain of pain with movement of the ear, chewing, swallowing or even lying on the particular ear. This infection can be easily seen and treated by your doctor. Many parents have found that this type of ear infection can be prevented, especially during the summer months. A few drops of a simple solution of white vinegar and rubbing alcohol in equal parts placed in each ear after swimming will help evaporate water from the ear canal.

The middle ear infection is a common problem of early childhood. These infections can be either viral or bacterial and often occur 7-10 days following the onset of cold symptoms. These infections are occasionally associated with fever, but often times are not. Our providers should see children with ear pain, so he can evaluate the ear, throat, and sinuses to decide whether antibiotics are necessary.

The pain associated with ear infection can be managed by using Acetaminophen or Ibuprofen as directed. Additionally, warm compresses or heating pad on low heat will allow some relief, until the doctor can see your child.

After treatment of an ear infection by an antibiotic, there is always a persistence of fluid remaining in the middle ear. This

fluid is the result of byproducts of our immune system and the infection itself. This fluid may take anywhere from 3-12 weeks to totally be cleared out of the middle ear. During this time your child may feel much better, yet still continue to "pull at his ears". This doesn't necessarily mean the ear infection has not cleared, simply that the remaining fluid has not been cleared. Your doctor may wish to see your child again in 2-4 weeks to check on the remaining fluid depending on the severity of the initial middle ear infection.

A major concern for hearing arises out of the persistence of middle ear fluid for longer than 3 months more so than the number of ear infections. If you feel your child's hearing has been or is still compromised after 1month, please contact your doctor.

VOMITING AND DIARRHEA

Many different illnesses can cause vomiting and diarrhea. For children these often are the result of intestinal viruses. These viruses are often seasonal in their occurrence (fall and winter months), however, due to nursery, daycare and sitter situations, these now occur throughout the year. They may present with a host of symptoms: fever, stomachache, body aches, vomiting, stomach cramping, and diarrhea.

The management for vomiting is essentially to give nothing by mouth for 1-2 hours. This allows your child's stomach to settle down. Once this has occurred, you may then start to offer small amounts of clear liquids ½ - 1 oz. at a time approximately every 30-45 minutes. If your child shows no improvement in vomiting after several attempts of small volume feeds, please contact your doctor.

Clear liquids for children less than 6 months of age include Pedialyte. For older children it is fine to use water or very watered down juice.

After the vomiting has been controlled for a few hours, you may advance their diet initially to include cheerios, crackers and toast, then slowly advance back to regular diet over the next 24-48 hours.

Diarrhea is the common end result of intestinal viral illnesses. Often times the vomiting is 24-36 hours in duration followed by 3-5 days of diarrhea. Diarrhea is characterized by frequent, greater than 6 per day, loose watery stools. During this time, although the diarrhea may be copious, it rarely by itself causes dehydration. A more important concern during the following days is with nutrition rather than attempting to stop the diarrhea. The diarrhea actually serves as a method for the body to rid itself of the virus. As such, do not use anti-diarrheal agents such as Imodium, as these delay the purge, prolonging the duration of diarrhea. As long as your child has loose stools the child should be considered contagious and other arrangements for daycare should be made regardless of whether there is fever present.

Dietary management of diarrhea can initially be accomplished similarly to management of vomiting. However, after 48 hours the diet may be advanced, and the child can be "fed through the diarrhea."

If your child has had diarrhea for more than 7 days or if there is high fever, bloody diarrhea or your child is not taking fluids well, please contact your doctor.

For infants who are breast-fed it is appropriate to continue breast-feeding. If your infant is formula-fed you may consider using a lactose-free since diarrhea often wipes the colon of the enzymes that typically process sugars, giving some a temporary lactose intolerance following these gastrointestinal illnesses. These formulas may be used for 5-7days and then switched back to regular formula.

The following signs should concern you for dehydration:

- Your infant <6 months old has not urinated in 6 hours
- Your child 6 months or older has not urinated in 8 hours
- Your child is not producing tears when crying
- The tongue looks dry and parched

If your child is approaching these signs, consider giving 5ml of water, diluted juice, or Pedialyte every 5 minutes for 1 hour. It is best to set a timer; 5 minutes goes by quickly. After one hour, if your child has mostly kept this down, you can advance to large

volumes. Your child should urinate within tow hours of initiating this regimen. If he has not, you should call your physician and may be referred to the emergency room or urgent care to get IV fluids.

RECOMMENDED READINGS

1. *Your Child's Health: The Parent's One-Stop Reference Guide to: Symptoms, Emergencies, Common Illnesses, Behavior Problems, Health Development* Barton D. Schmitt, Bantom Press 2005.
2. *My Child is Sick!: Expert Advice for Managing Common Illnesses* Barton D. Schmitt, American Academy of Pediatrics, 2016
3. *Solve Your Child's Sleep Problems*. Richard Ferber.
4. *The No-Cry Sleep Solution: Gentle Ways to Help Your Baby Sleep Through the Night* Elizabeth Pantley
5. *It's No Accident: Breakthrough Solutions to Your Child's Wetting, Constipation, UTIs, and Other Potty Problems* Steven Hodges and Suzanne Schlosberg

RECOMMENDED WEBSITES FOR REFERENCE

HealthyChildren.org
Kidshealth.org
JanetLansbury.com
TheCarSeatLady.com
http://www.chop.edu/centers-programs/vaccine-education-center

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