A Parent's Guide

Birth through Adolescence

- Common Illnesses and Issues
- Behavior and Development
- Nutrition and Eating

The Everett Clinic
Part of Optum®

everettclinic.com

A Parent's Guide:

Birth through Adolescence

FOREWORD

This handbook has been prepared by the staff and physicians of The Everett Clinic. Its purpose is to offer descriptions and treatments of common pediatric and adolescent health problems, provide tips on promoting positive parenting and help familiarize you with The Everett Clinic Family Medicine and Pediatric departments' services.

We welcome any comments or suggestions on how we can better serve you. Our goal is to promote physical and emotional health in your child or adolescent. This handbook is designed to help you meet that goal.

The Everett Clinic

Part of Optum®

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General Information: Family Medicine and Pediatric Departments

Ages

Both departments treat children and adolescents from birth through 21 years of age. Family Medicine also sees adults.

Telephone Calls

Your call will be answered by one of our patient representatives who can assist you with scheduling and questions about your appointment.

If you have health-related questions, the representative will help connect you with our clinical teammates.

We try to assist each patient as promptly as possible, but may at times ask you to hold. You can help us decrease the wait times by keeping this book handy and reviewing it when needed. Many times, the answers can be right here!

Insurance

Please contact your insurance provider for details of your coverage benefits before seeking routine, acute or emergency care. **Never delay in seeking care for a potentially life-threatening illness.**

For help finding a provider in your network or for specific coverage information, call your insurance provider directly.

Missed Appointments

Failure to cancel an appointment prevents someone else from receiving care. Please remember to call if you cannot keep your appointment.

The Everett Clinic policy allows providers to charge for missed appointments or to permanently discontinue care with any patient who misses two or more appointments. If you miss more than two appointments, you may jeopardize your ability to be seen at The Everett Clinic.

If circumstances exist that make it difficult for you to keep your scheduled appointment, please bring this matter up with your healthcare provider and we will do our best to accommodate your needs.

Seeking Care

For Life-Threatening Emergencies

Dial 911 immediately and ask for assistance.

For Sudden or Unexpected Illness

Unexpected illnesses and acute concerns can strike at any time. Your care team can be reached with questions about your child's health:

- Monday - Friday, 7 am - 8 pm
- Saturday 8 am - 8 pm
- Sunday 8 am - 5 pm

For medical questions outside regular business hours that can't wait, you can reach our on-call care team by calling the Answering Service at 425-258-9000.

For acute issues, your provider may respond to your concerns by phone or may ask you to schedule an appointment. Depending on the circumstances, you may be referred to a Walk-In Clinic or Saturday Pediatric Care Clinic.

Our urgent care Walk-In Clinics provide convenient treatment for non-life-threatening medical conditions. Walk-In Clinics are open seven days a week and no appointment is necessary.

Walk-In Clinic Locations

For a current list of Walk-In Clinic locations wait times and to reserve your spot online, visit everettclinic.com/WIC

Our Saturday Pediatric Care Clinic is open Saturdays from 9 am – 3 pm at select locations. We accept both existing and new patients for routine exams or unexpected illness. Learn more at everettclinic.com/pedsclinic.

For Routine Physicals and Other Visits

Appointments for routine physicals are typically booked out several weeks. Call as far in advance as possible to schedule your child's physical to ensure you can find an appointment time convenient for you.

For chronic health issues, your provider may schedule regular follow-up visits in advance at appropriate intervals.

Emergency Rooms

Seattle Children's Hospital
4500 40th Ave NE Seattle 206-987-2222

EvergreenHealth, Kirkland Campus
12040 NE 128th St Kirkland..... 425-899-1700

Northwest Hospital
1550 N 115th St Seattle 206-668-1765

Providence Regional Medical Center, Colby Campus
1321 Colby Ave Everett..... 425-261-3000

Swedish, Edmonds Campus
21601 76th Ave W Edmonds..... 425-640-4000

Well-Child Exams

Recommended schedule for well-child exams

Not all insurance plans cover the recommended schedule for well-child exams, so please check with your insurance company. At each well-child visit, your child's growth, development and physical health will be evaluated. Other topics such as nutrition, behavior, discipline, sleep and safety may be discussed. If needed, immunizations will be administered. Visits to the healthcare provider when your child is ill do not replace routine well-child exams.

3–5 days old ..... Newborn exam
7–30 days old ..... Well-child exam
2 months old ..... Well-child exam
4 months old ..... Well-child exam
6 months old ..... Well-child exam
9 months old ..... Well-child exam
12 months old ..... Well-child exam
15 months old ..... Well-child exam
18 months old ..... Well-child exam
2 years old ..... Well-child exam
3 years old ..... Well-child exam
4 years old ..... Well-child exam
5 years old ..... School physical exam
6–21 years old ..... Physical exam every year

Immunizations

Why immunize your child?

Immunizations help protect your child and those he contacts from serious diseases, such as measles, polio and whooping cough. In this country, we see very few cases of these disease because large numbers of children and adults have been immunized. Thanks to global immunization efforts, smallpox has been completely eliminated, polio has been eliminated from most of the world, and what used to be a common cause of meningitis in babies, hemophilus influenza type B, has become uncommon in this country.

If we do not keep immunizing the majority of children and adults, these preventable disease will make a comeback.

What about side effects?

In recent years people have become concerned about the safety of some vaccines. Vaccines have been improved to minimize the possibility of side effects. The chance of a significant reaction is now likely less than 1 in 100,000, which extremely rare!

Studies show that conditions such as autism are actually mostly genetic, and thus are not related to immunizations. People were also concerned about mercury (used as a preservative in vaccines). Even though it was never scientifically shown to put children at risk, it is no longer used in any pediatric vaccines.

What can you do?

Please make sure your child is up to date on his immunizations. If you have concerns about the safety of any immunization, ask your doctor. He or she will be happy to discuss your concerns and provide appropriate reference materials.

Saturday Pediatric Care Clinic

When your child is sick or hurting, you want care right away. Our Saturday Pediatric Care Clinics are open to all—existing and new patients—for current health concerns, school physicals, sports physicals or well-child checks. Open Saturdays from 9 am - 3 pm at select locations.

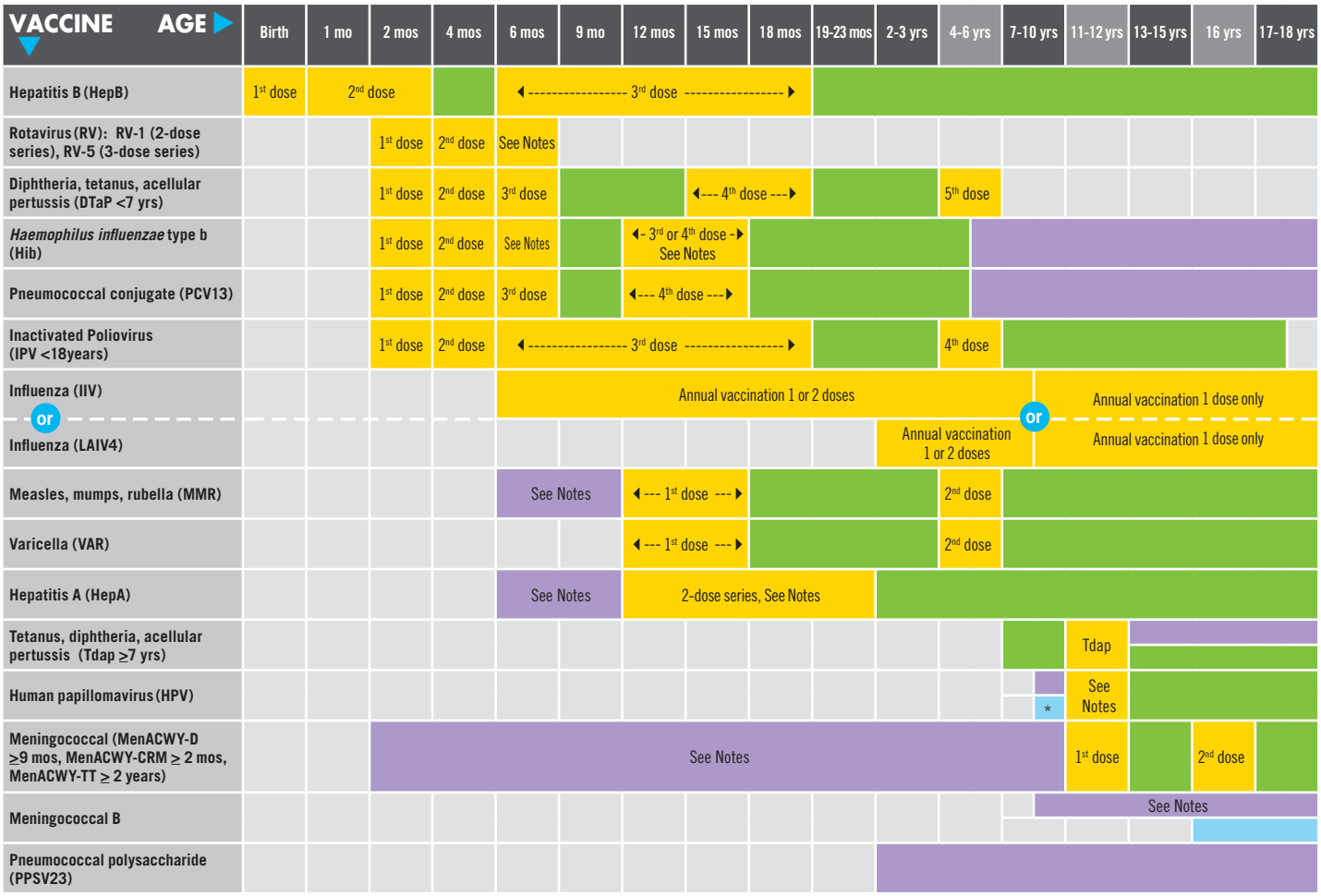
Call ahead starting Thursdays to make an appointment or call after 8:30 am Saturday for a same-day appointment. Call any Everett Clinic Pediatric department to schedule.

Learn more at everettclinic.com/pedsclinic.

Recommended Child and Adolescent Immunization Schedule

for ages 18 years or younger, United States, 2021

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, ask you Primary Care Provider. School entry and adolescent vaccine age groups are shaded in gray.



NOTES —Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

For vaccine recommendations for persons 19 years of age or older, see the Recommended Adult Immunization Schedule, 2021.

ADDITIONAL INFORMATION

• COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/.

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2018 Report of the Committee on Infectious Diseases. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, ask your Primary Care Provider.

Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

continued on next page

**** For those who fall behind or start late, see the catch-up schedule: http://www.cdc.gov/vaccines/schedules/hcp/imz/catchup-shell.html***

Provided by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination
- For other catch-up guidance, ask your Primary Care Provider.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series (minimum interval: 6 months) beginning at age 12 months

Catch-up vaccination

- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB (**Heplisav-B®**) at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, ask your Primary Care Provider.

Special situations

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination:** 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2020, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only:** Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Children less than age 2 years
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination

- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

Special situations

International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

Routine vaccination

- 2-dose series at 11–12 years, 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

continued on next page

- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/):

- Children less than age 24 months:
  - **Menveo (age 2–23 months)**
    - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose Menveo, Menactra, or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo**, **Menactra**, or **MenQuadfi**

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- Children for whom boosters are recommended because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- Children for whom boosters are not recommended (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Shared clinical decision-making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series.

For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, ask your Primary Care Provider.

Special situations

Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents age 18 years or older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, ask your Primary Care Provider.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix**: 2-dose series at 2 and 4 months
- **RotaTeq**: 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, ask your Primary Care Provider.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - Children age 7–9 years who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - Children age 10 years who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- DTaP inadvertently administered on or after age 7 years:
  - Children age 7–9 years: DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - Children age 10–18 years: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, ask your Primary Care Provider.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older*

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see MMWR at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years:** routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older:** routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

Common Illnesses and Issues:

Recognizing symptoms and when to call your child's provider

Acne

Acne occurs during the adolescent and young adult years. It can consist of blackheads, whiteheads (pimples), or red bumps on your face, neck and shoulders.

Cause

- Acne is due to an overactivity and plugging of the oil glands. More than 90 percent of teenagers have some acne. The main cause of acne is increased levels of hormones during adolescence.
- Acne is not caused by sexual activity. It is not caused by dirt nor by not washing your face often enough. The tops of blackheads are black because of the chemical reaction of the oil plug with the air.

Home care

There is no magic medicine at this time that will cure acne. However, good skin care can keep acne under control and at a mild level.

Basic treatment for all acne:

- **Soap:** Wash your skin twice a day and after exercise. The most important time to wash is at bedtime. Use a mild soap such as Dove® soap, Cetaphil® or a gentle acne wash.
- **Hair:** Shampoo your hair daily.
- **Avoid picking:** Picking stops acne from healing and can cause scarring.

Treatment for whiteheads and blackheads:

Benzoyl peroxide 5% lotion or gel:

- This lotion helps to open pimples and unplug blackheads. It also kills bacteria. It is available without a prescription, though some insurance plans may cover a prescription.
- Apply the lotion once a day at bedtime.
- An amount of lotion the size of a pea should be enough to cover most of your face. If your skin becomes red or peels, you are using too much of the medicine or applying it too often. Try using less of it or applying it less often. You may need to use this lotion for several years.

Treatment for red bumps:

Large red bumps mean the infection has spread beyond the oil gland. You may also need an antibiotic or other types of medicines. These medications can only be prescribed by your provider or nurse practitioner.

Common mistakes in treating acne:

- **Avoid scrubbing your skin.** Hard scrubbing of the skin is harmful because it irritates the openings of the oil glands and can cause them to be more tightly closed.
- **Avoid putting any oily or greasy substances on your face.** Oily and greasy substances make acne worse by blocking oil glands.
- **Don't stop your acne medicine too soon.** It takes 4–8 weeks after starting to see a good response.

Call during office hours if:

- The acne has not improved after you have treated it with benzoyl peroxide for two months.
- It looks infected (large, red, tender bumps).
- You have other concerns or questions.

Asthma

What is asthma?

Asthma is a chronic disease of the tubes that carry air to the lungs. The inner lining of the airways become swollen (inflammation) and the muscles around the airways tighten (bronchospasm) narrowing the airways further. The severity of asthma varies over time, and patients may not always have symptoms. When asthma is controlled, your child should be able to do everything someone without asthma can do.

Symptoms of asthma include:

- Wheezing
- Coughing, especially at night
- Shortness of breath
- Tightness in the chest

If you are concerned your child may have asthma, talk to your healthcare provider.

Diagnosis

It can be challenging, especially in young children, to be certain that asthma is the diagnosis. After examining your child, your provider will need to ask you specific questions about your child's health. The information you give will help determine if your child has asthma. This information includes:

- Your child's symptoms, such as wheezing, coughing, and shortness of breath
- What triggers the symptoms or causes the symptoms to get worse
- Medications that were tried and if they helped
- Any family history of allergies or asthma

Once your child is old enough, we can check airway function using a device called a spirometer, which measures the amount of air blown out of the lungs over time. Another spirometry may be done after your child takes asthma medication, to compare. Keep in mind, not all children with repeated episodes of wheezing have asthma.

Treatment

One goal of treatment is to reduce symptoms so your child can enjoy normal physical activities without discomfort. A second goal is to control symptoms well enough to prevent attacks that would require emergency care or hospitalization.

Asthma is different in every patient and symptoms can change over time. Factors such as your child's age and the severity and frequency of her symptoms will influence which therapeutic approach will work best. Your child may need to take medication every day, or only once in a while, depending on her symptoms. Some children need to take a combination of medications to achieve the best results. Your provider may prescribe several medications to get symptoms under control at the start, then decrease the medications over time.

Asthma medications are divided into two groups: quick-relief medications and controller medications. Inhalers should always be used with a "spacer" or "chamber" to optimize medication delivery. Please discuss this with your provider.

Quick-relief medications

Quick-relief medications (bronchodilators) are for short-term use to open up narrowed airways and help relieve feeling of tightness in the chest, wheezing and breathlessness. They can also be used to prevent exercise-induced asthma. The most common quick-relief medication is **albuterol**.

Controller medications

Controller medications are used on a daily basis to control asthma and reduce the number of days your child has symptoms. They are not used for relief of symptoms. Children with asthma symptoms more than twice per week or those who are woken up by their asthma more than twice per month should be on controller medications. These medications need to be taken every day, even if your child is feeling well.

Inhaled corticosteroids, such as **Flovent**, **Pulmicort** and **Qvar** are very effective and, when used in the recommended doses, are safe for most children.

Asthma action plan

It is helpful to have an asthma action plan in writing. It should contain information on daily medications your child takes as well as instructions on what to do for symptoms. Ask your provider to help you create an action plan for your child.

Exercise-induced asthma

Exercise can trigger symptoms in children with asthma. It can almost always be prevented with use of albuterol taken 15 minutes or more before exercise. If it occurs frequently, however, it may mean your child's asthma is not under control. Proper asthma control can make a great difference in the ability of a child to exercise normally.

Monitoring

If your child suffers from asthma, regular, more frequent check-ups may be necessary to ensure symptoms are not worsening.

Your provider will ask you to complete an ACT/Track form to asses your child's symptoms.

Get a flu shot every fall

Patients with asthma are at a much greater risk for complications when they are sick with influenza. Therefore, all patients and their household contacts are encouraged to get an annual flu vaccine..

Additional information:

American Academy of Pediatrics, aap.org

National Heart, Lung, and Blood Institute (NHLBI) Health Information Center, nhlbi.nih.gov

American Academy of Allergy, Asthma, and Immunology, aaaai.org

Asthma and Allergy Foundation of America, aafa.org

The Everett Clinic, everettclinic.com/pediatricasthma

Adapted from information provided by the American Academy of Pediatrics.

Autism

What is autism?

Autism spectrum disorders are a group of biologically-based neurodevelopmental disorders characterized by impairments in socialization, communication and behavior. The spectrum includes children with Aspergers syndrome, pervasive developmental disorder (PDD) and autism. Some children have very minor difficulties with language or peer relations, while other children may be completely non-verbal and unable to attend regular school. Autism is not rare; it is estimated to affect about 1 in 88 children.

What causes autism?

Nobody fully understands the cause of autism. We know it is partly genetic. Many studies have looked for a possible connection between childhood immunizations and autism, but have found no connection. Scientists are looking for other causes such as viral illnesses or exposure to possible toxins.

We do know that autism is not anyone's fault. It is not due to anything the child or parent did wrong.

How is autism diagnosed?

Autism is diagnosed by your primary care provider or a specialist in autism over time with the input of parents, family members, teachers and daycare providers. You will be asked questions about your child's development and behavior at every well-child exam, starting with the very first visit. If you have concerns at other times, schedule a visit. Never feel your concerns are silly.

Early symptoms and signs can include:

- No babbling by 9 months
- No pointing or gesturing by 12 months
- No single words by 15 months
- No two-word phrases by 24 months
- Poor social skills
- No pretend play by 18 months
- Any loss of language or social skills at any time

How is autism treated?

Treatment includes developmental services through the school district if your child is at least 3 years old, and the Early Intervention (birth-to-three) program for younger children. Parents will become very involved with therapy for their children. Ongoing support is available through your primary care provider as well as numerous community agencies.

Where can I learn more about autism?

- Talk with your child's provider about your questions.
- The CDC's "Learn the Signs. Act Early" site (cdc.gov/ncbddd/autism/actearly)
- The CDC's Autism Information Center (cdc.gov/ncbddd/autism/index.htm)

Chicken Pox *Varicella*

The illness:

Chicken pox is a viral infection caused by the varicella-zoster virus, and is associated with a fever and a rash. The rash starts as red bumps, but within 24 hours the bumps become water blisters located anywhere on the body. The rash can be itchy and the child may have body aches. The incubation period for chicken pox is 10–20 days and a child is contagious until all the blisters have scabbed over.

The immunization:

Chicken pox is uncommon now because most children have had the varicella vaccine. Two doses are recommended before kindergarten age. Some children who have had the vaccine will still get chicken pox, but it tends to be mild. There may be only a few bumps, and rather than turning into water blisters, the bumps develop a crust on top.

Even though chicken pox used to be common, it can still have serious consequences. Some children develop complications such as severe secondary skin infections, pneumonia or brain inflammation. It can be very dangerous for people of all ages with a compromised or weakened immune system. About a hundred people die every year from complications of chicken pox.

It's important to have your child vaccinated!

Chicken Pox *Varicella* *continued*

Treatment:

Itching can be relieved by lukewarm oatmeal baths or anti-itch creams such as calamine. Oral antihistamines may help, especially at bedtime. Acetaminophen can be given for fever if needed. Never give children aspirin. Make sure your child stays hydrated.

Call our office if:

- Your child's rash develops unusual redness, swelling, pain or drainage
- Your child has extreme lethargy, dehydration or severe stomachache
- You feel frightened or worried about your child's illness

Adapted from: Author: Anne A. Gershon, MD; Professor of Pediatrics; Director, Pediatric Infectious Diseases; Columbia University College of Physicians and Surgeons; New York, NY.

Colds and Flu

Colds and flu are illnesses caused by viruses. Most healthy children have 8–10 viral infections each year. Each infection usually lasts from 7–14 days, and a cough can persist for weeks. This means your child may have a runny nose for as much as one third of the year.

Symptoms of viral illness may include runny or congested nose, cough, sore throat, eye discharge, muscle aches, headache, vomiting and diarrhea. Your child may have a fever for the first few days.

There are no cures for viral illnesses; antibiotics are ***not*** helpful. However, your provider may be able to make recommendations to help relieve discomfort.

Closely monitoring your child's symptoms may offer clues that complications are occurring: increasing irritability, lethargy, changes in sleep and feeding patterns (especially in infants and younger children). Other signs might include a cough that is becoming progressively worse, increased breathing rate, fever for more than four days or complaints of ear pain.

Colds and flu are contagious illnesses; in fact most are contagious 12 days before any symptoms develop. Children should be kept home from school if their symptoms would not allow them to pay attention in class or would disturb other children in the classroom. Children usually restrict their own activity level, resting when they feel tired, so there is generally no need for you to restrict their activity.

Over-the-counter cold and cough medicines (decongestants, antihistamines, expectorants, mucolytics, cough suppressants) are generally not helpful for children under 12 years old. Many of these medications have side effects which can interrupt your child's sleep or cause behavior changes. Hundreds of children visit the emergency department every year for overdoses or unexpected side effects of these medicines.

We do not recommend over-the-counter cold and cough medicines for children, especially those under six years old.

Colds usually get better by themselves within 7–14 days, though cough often persists. Make sure your child is drinking plenty of fluids and getting rest. Acetaminophen or ibuprofen can be used if needed for pain or fever. Saline nose drops are safe, though they are rarely necessary.

When should I call my child's healthcare provider?

Call IMMEDIATELY if your child develops:

- Marked lethargy* or irritability

Call during regular hours if your child has:

- Difficulty breathing
- Worsening cough
- Ear pain
- Severe sore throat
- Cold or flu symptoms in infants two months or younger
- No improvement over five days
- Signs of dehydration**
- Fever for more than four days that is not starting to come down

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* *Lethargy is defined as listlessness, no eye contact, or no response to voice or touch.*

** *Adequate hydration is defined as taking in and keeping down enough fluids to urinate at least three times in a 24-hour period.*

Colic *and Infant Crying*

Normal infant crying

Young infants normally cry about 2–3 hours per day. Crying is a way for infants to communicate with their caregivers. Babies cry when they are hungry, tired, bored, in pain and to relieve stored-up tension.

Although crying is normal, it is important to **LISTEN** to your baby's cry and **ASSESS** why she is crying. For example, it's very common for babies to cry just before feeding time because they are hungry or when putting them down for a nap because they are tired. Another normal cry period for young babies seems to be the evening period.

Ask yourself some questions when you hear your baby cry: Is she hungry? Does she need to sleep? Does she need her diaper changed? Could she have some trapped gas and need to burp? Is she sick? Has the day been very busy and the baby is over-stimulated? Attempt to answer these questions and meet your baby's needs.

Some babies will cry and you will not be able to comfort them. Before assuming it is colic, please consult with your healthcare provider to make sure the baby is healthy and growing properly.

Colic

Colic is excessive fussiness and crying in an otherwise healthy, well-fed baby. About 10 percent of infants have colic. It usually begins in the first few weeks of life and decreases by the third month. Evening hours tend to be the worst time of day for colic symptoms.

The following suggestions can make colic easier to live with, but will not make the colic disappear. Colic will go away as the baby matures. No one really knows what causes colic. Remember that your baby is not sick and the colic will pass with time.

Some positions or things to try:

- Rock the child in a chair or place the child in an infant swing
- Walk briskly holding the baby
- White noise tapes, waterfall tapes and heartbeat tapes
- Car ride or stroller ride
- Snuggling, swaddling and cuddling; a Snugli-type pack may be helpful

If you are nursing your baby, don't stop breast-feeding thinking an artificial infant formula will solve the problem. Nursing mothers are often given advice from family and friends to avoid certain foods in their diets to cure colic in their infant. Rarely can foods you eat actually be implicated as the cause for your infant's colic. In fact, most babies show no change in their crying patterns when mothers avoid such things as spicy foods, broccoli, cauliflower, onions, beans, garlic or milk.

If none of these measures quiets your baby and she has been fed in the last two hours, you may let your baby cry herself to sleep. On some days, this is the only answer for a fussy baby. Sometimes a crying baby can be frustrating. **Remember, never shake your baby.**

If colic comes on suddenly, check your baby carefully from head to toe for a thread or hair wound around a toe or something poking the baby.

Remember, special bottles, formulas or medicines do not cure colic.

Hang in there!

Having a baby with colic is an extremely frustrating and exhausting experience. It does not mean you are not wonderful, loving parents. Sometimes a baby just has to cry to release tension and nothing you do will prevent it.

Although it is very tough to listen to your own baby cry, it is not harmful for her. Most babies outgrow colic by 3–4 months of age and grow up to be happy, healthy children. Talk with other parents who have had a colicky baby.

Try to be patient—you will get through it!

Constipation

For infants less than one year old

It is not necessary to have a bowel movement every day. Some infants have bowel movements (BMs) only once every 3–7 days, and they are perfectly normal.

Constipation can be a concern when the stool is very hard or when the baby experiences pain when passing stool. Babies less than six months of age commonly grunt, push, strain, draw up the legs and become flushed in the face during passage of BMs. These behaviors are normal and should remind us that it takes some time for the bowels and rectum to become coordinated.

Dietary changes are usually all that is necessary to treat your baby's constipation. However, if you have concerns, talk to your healthcare provider.

Constipation *continued*

Call our office if:

- More than seven days have passed without a BM, and your baby is not breast-fed.
- Bright-red blood has been noticed on the stool more than twice.
- You are using suppositories or enemas to treat your baby's constipation.
- Your baby is in pain when having bowel movements.

For toddlers and children

Constipation is a common and recurrent problem throughout the childhood years. Constipation is nearly always responsive to dietary changes. A diet high in fiber with plenty of fluids is very helpful in preventing constipation. Encourage your child to eat oatmeal, Cheerios®, bran muffins, Raisin Bran®, grapes, plums, prunes, prune juice, dried apricots, dried cranberries, raisins, dates, figs, popcorn, salads and whole grain foods. Cook with whole grains, such as barley and quinoa, and look for whole grain versions of pastas, breads and other snacks. Avoid constipating foods such as white rice, applesauce, bananas and too much dairy.

Encourage sitting on the toilet twice a day after meals and offer a special toy to play with. Try a warm bath which may help with relaxation.

If your doctor recommends it, you can buy MiraLAX® (glycolax) over the counter. Put one capful of powder in eight ounces of water or juice and drink that once a day. This supplement pulls more water into the colon and makes stools softer and easier to pass. The goal is at least one soft, easy, painless stool per day.

Please call our office if:

- Child has severe abdominal pain
- You are considering using enemas, laxatives or suppositories
- Child is soiling his pants
- Child is developing "toilet fears"

Croup

Description of croupy cough

- All children with croup have a tight, low-pitched "barking" cough.
- The voice is usually hoarse.

Description of stridor *(seen with severe croup)*

- When your child breathes in, you hear a harsh, raspy, vibrating sound.
- Breathing is very difficult.
- Stridor is usually present only with crying or coughing.
- As the disease becomes worse, stridor also occurs when a child is sleeping or relaxed.

Cause

Croup is a viral infection of the vocal cords, voice box (larynx) and windpipe (trachea). It is usually part of a cold. Swelling of the vocal cords causes hoarseness, and potentially stridor.

Stridor occurs as the opening between the vocal cords becomes more narrow.

Expected course

Croup usually lasts for 5–6 days and generally gets worse at night. During this time, it can change from mild to severe many times. Symptoms are worse for children under 3 years of age.

First aid for attacks of stridor with croup

If your child suddenly develops stridor or tight breathing, do the following:

1. **INHALATION OF MIST:** Moist air seems to work best to relax the vocal cords and break the stridor; try a humidifier or vaporizer, or take the child out in the cold night air.

   OR

2. **THE FOGGY BATHROOM:** Have a hot shower running with the bathroom door closed. Once the room is all fogged up, take him in for at least 10 minutes. Try to help your child not be afraid by cuddling or reading a story. The more relaxed he is, the better.

WARNING SIGNS:

Most children settle down with the above treatments and then sleep peacefully through the night. If your child continues to have stridor or difficulty breathing, call your child's physician IMMEDIATELY. If your child turns blue, passes out or stops breathing, call 9-1-1.

Home care for a croupy cough without stridor

3. **HUMIDIFIER:** Dry air usually makes cough and congestion worse. Keep the child's bedroom humidified. Use a cool mist humidifier if

you have one. Run it 24 hours a day. You may also try sitting in a steamy bathroom with hot shower running for 10–20 minutes.

4. **EXPOSURE TO OUTSIDE AIR:** Cool air often helps shrink swollen mucus membranes and helps with the symptoms of croup. Bundle your child warmly and go outside for 20 minutes.
5. **THERE ARE NO COUGH MEDICINES THAT HELP WITH CROUP OR ANY OTHER COUGH**. Do not use cold/cough medicines or Vicks®.
6. **CLOSE OBSERVATION:** While your child is croupy, sleep nearby so you can hear her.
7. **CONTAGIOUSNESS:** The viruses that cause croup are quite contagious until the fever is gone or at least during the first three days of illness. Your child can return to school or child care once he feels better.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- Breathing becomes difficult.
- Your child starts drooling, spitting or having difficulty swallowing.
- Cool mist or steam fails to clear up the stridor in 20 minutes.
- Your child starts acting very sick.

Call within 24 hours if:

- Attacks of stridor occur more than three times.
- A fever lasts more than four days.
- Croup lasts more than 10 days.
- You have other concerns or questions.

Diaper Rash

What is a diaper rash?

A diaper rash is any rash on the skin area covered by a diaper. Almost every child gets diaper rashes. Most of them are due to prolonged contact with moisture, bacteria and ammonia. Bouts of diarrhea cause rashes in most children.

How long will it last?

With proper treatment these rashes are usually better in three days. If the rash does not improve with treatment, then your child probably has a yeast infection (candida). If your child has a yeast infection, the rash becomes bright red and raw, covers a large area and is surrounded by red dots.

How can I take care of my child?

- **CHANGE DIAPERS FREQUENTLY:** The key to successful treatment is keeping the area dry and clean so it can heal itself. Check diapers about every hour, or as often as possible, and change wet or soiled diapers immediately. Make sure your baby's bottom is completely dry before closing up a fresh diaper.
- **INCREASE AIR EXPOSURE:** Leave your baby's bottom exposed to the air as much as possible each day.
- **DO NOT WIPE** when baby urinates only (urine is sterile). Clean stool gently with a soap-free wipe.
- **CREAMS AND OINTMENTS:** Most babies don't need any diaper cream. However, you can apply an ointment to protect the skin after cleansing. A barrier ointment, such as Vaseline®, A&D Ointment® or Desitin®, is also likely to help whenever your child has diarrhea.
- **YEAST INFECTIONS:** If the rash is bright red or does not start getting better after three days of warm water cleaning and air exposure, your child may have a yeast infection. Apply an over-the-counter medication such as clotrimazole cream (such as Lotrimin® or Mycelex®) or other anti-fungal ointment (such as Monistat®) four times a day, with a barrier cream on top.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- The rash looks infected (pimples, blisters, boils, sores).
- Your child starts acting very sick.

Call within 24 hours if:

- The rash isn't much better in three days.
- The diaper rash becomes bright red or raw.
- You have other concerns or questions.

Diarrhea

Diarrhea is the sudden increase in the frequency and looseness of bowel movements (BMs). The best indicator of the severity of the diarrhea is its frequency.

The main complication of diarrhea is dehydration from the loss of too much body fluid. Symptoms of dehydration are a dry mouth, the absence of tears, infrequent urination and a darker, concentrated urine. The main goal of diarrhea treatment is to prevent dehydration.

Cause

Diarrhea is usually caused by a viral infection of the lining of the intestines (gastroenteritis). Sometimes it is caused by bacteria or parasites. Occasionally a food allergy or drinking too much fruit juice may cause diarrhea.

Expected course

Diarrhea caused by a virus usually lasts several days to two weeks regardless of treatment. The main goal of treatment is to prevent dehydration. Your child needs to drink enough fluids to replace the fluids lost in the diarrhea. Don't expect a quick return to solid bowel movements. In fact, following a viral infection, it can take up to two months for stools to return to normal.

Home care guidelines

If your child is vomiting, these guidelines may not be sufficient. Please refer to the article about vomiting on page 28.

FORMULA-FED INFANTS *(less than one year old and no evidence of dehydration)*

Diet

Continue to feed your child full-strength formula or his usual diet without any changes, unless some aspect of his diet seems to make things worse.

Glucose-electrolyte solutions

If your child is not getting enough fluids from his usual diet to maintain hydration, you can supplement with Pedialyte® for the first 24 hours. Give your baby as much fluid as he wants. Diarrhea makes children thirsty, and your job is to satisfy that thirst and prevent dehydration. Never restrict fluids when your child has diarrhea.

BREAST FED INFANTS *(less than one year old and no evidence of dehydration)*

No matter how they look, the bowel movements of a breast-fed infant are usually normal unless they contain mucus, blood or develop a bad odor.

During the first 2–3 months of life, a breast-fed baby may normally have one stool after each feeding. However, if your baby's bowel movements abruptly increase in number, your baby probably has diarrhea. Other clues are poor eating, vomiting, acting sick or fever.

Diet

If your breast-fed baby has diarrhea, treatment is straightforward. Continue breast-feeding, but at more frequent intervals. Don't stop breast-feeding your baby because your baby has diarrhea. For severe (watery and frequent) diarrhea where your baby is urinating less frequently than normal, offer Pedialyte between breast-feedings for 6-24 hours..

Home care: other aspects

Prevention

Viral diarrhea is very contagious. Always wash your hands after changing diapers or using the toilet. This is crucial for keeping others in the family from getting diarrhea.

Diaper rash from diarrhea

The skin near your baby's bottom can become irritated by the diarrhea. Wash the area gently after each bowel moment and then protect it with a thick layer of zinc-oxide based diaper cream such as Desitin® or A&D® ointment.

Vomiting and diarrhea

If your child has vomited more than twice, follow the recommended treatment for vomiting on page 28 until your child has gone eight hours without vomiting.

Do not give any over-the-counter diarrhea medications, except probiotics, unless recommended by your provider.

Call your healthcare provider if:

- There are signs of dehydration (no urine in more than eight hours, very dry mouth, no tears).
- Any blood appears in the diarrhea.
- Your child vomits up clear fluids three or more times.
- Your child starts acting very sick.
- A fever lasts more than three days.
- Mild diarrhea lasts more than two weeks.

Drug Doses for Over-the-Counter Medications

Acetaminophen and Ibuprofen Dosing Chart

Companies are changing the concentration of acetaminophen medication for infants. There are new dosing directions for these products. Confirm which product you have before measuring the dose to ensure you are using the correct amount. **Always** measure with the dosing device provided with the product.

Dosing of acetaminophen and ibuprofen is by weight. Age ranges are given for general guidance only.

WEIGHT *AGE*	**8-12 lb.** *1-3 months*	**12-17 lb.** *4-11 months*	**18-23 lb.** *12-23 months*	**24-35 lb.** *2-3 years*	**36-47 lb.** *4-5 years*	**48-59 lb.** 6-11 years
Acetaminophen **Infant Solution** 160mg/5mL 	1.25mL (40mg)	2.5mL (80mg)	3.75mL (120mg)	5mL (160mg)	7.5mL (240mg)	10mL (320mg)
Acetaminophen **Suspension/Solution** 160mg/5mL 	—	2.5mL (80mg)	3.75mL (120mg)	5mL (160mg)	7.5mL (240mg)	10mL (320mg)
Ibuprofen **Infant Drops** 50mg/1.25mL 	—	1.25mL* (50mg)	1.875mL (75mg)	—	—	—
Ibuprofen **Children's Solution** 100mg/5mL 	—	—	3.75mL (75mg)	5mL (100mg)	7.5mL (150mg)	10mL (200mg)

Acetaminophen may be given every 4–6 hours, not more than five times in 24 hours.

Ibuprofen may be given every 6–8 hours, usually no more than three times in 24 hours.

Ibuprofen is **NOT** recommended for infants less than 6 months of age.

Ear Infection *otitis media*

What is otitis media?

Otitis media means inflammation of the middle ear. The inflammation occurs as a result of a middle ear infection. It can occur in one or both ears.

Otitis media is very common in young children but rare in adults. It usually occurs in the fall, winter and early spring months.

What are the symptoms of otitis media?

The most prominent symptoms are a feeling of pressure or blockage in the ears and persistent ear pain. Children may tug on their ears, perhaps as a reaction to the discomfort or pain. Other symptoms may include fever, irritability or fussiness, nausea and vomiting.

Hearing can also be somewhat muffled. This happens because the fluid in the middle ear prevents the eardrum from functioning as it should. The result is temporary hearing loss. Once the fluid drains, full hearing is restored.

What is the treatment for otitis media?

Eighty percent of children with otitis media get better without antibiotics. Antibiotics are often prescribed for children under two with persistent pain despite Tylenol/Motrin, fever, vomiting or a history of frequent ear infections.

Regardless of whether antibiotics are prescribed, treatment to reduce pain is helpful. In many instances, acetaminophen or ibuprofen will provide good pain relief. Home remedies such as applying warm compresses to the outer ear may be helpful.

How can I help prevent otitis media?

- **Protect your child from secondhand tobacco smoke.** Children exposed to tobacco smoke have an increased risk of ear infections.
- **Reduce your child's exposure to colds during the first year of life.** Most ear infections start with

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a cold. Try to delay the use of large daycare centers during the first year by using a sitter in your home or a small home-based daycare.

- **Breast-feed your baby during the first 6–12 months of life.** Antibodies in breast milk reduce the rate of ear infections.
- **Avoid bottle propping.** If you bottle feed, hold your baby at a 45° angle. Feeding in the horizontal position can cause formula and other fluids to obstruct the eustachian tube. Weaning your baby from a bottle between 9–12 months of age will help stop this problem.

Eczema

Eczema is the condition of having dry skin, sometimes allergic, always itchy. It can involve just the elbows and knees, or it can involve the whole body. It comes and goes, gets better and worse, but tends to be chronic.

The cause

Eczema is often inherited and tends to occur in children and families with asthma, hay fever and other allergies. Sometimes food allergies contribute to eczema, especially in infants.

Treatment

Eczema is very treatable, but it takes patience and persistence to gain good control.

Bathing

Dryness of the skin is the main problem. Since hot water and soap both tend to take the natural oils out of our skin, bathing habits are extremely important in controlling eczema.

For infants and small children, a bath every day is fine, using warm rather than hot water. It's best to use no soap at all. Things that get on babies' skin such as milk, sweat and saliva, all wash off with water. A shampoo once a week is plenty, though getting your child's hair wet with water at every bath is fine. It's best not to let your child sit in the shampoo rinse water. Transition your child to showers as soon as she's ready.

Adolescents generally shower every day, but should use warm water rather than hot. A gentle soap such as Dove® can be used, in the skin fold areas only—armpits, neck, and groin. No soap is needed on the arms, legs, stomach or back. Teenagers generally need to shampoo their hair every day.

Moisturizers:

Immediately after towel-drying, while you're still in steamy bathroom, use a generous amount of scent-free, dye-free moisturizer. The thicker and greasier the better. You can try Vaseline®, Cerave®, Aquaphor®, Eucerin®, Lubriderm®, Nivea®, Keri®, Curel® or baby oil. Always buy the type in a tub rather than a pump bottle or tube. Use a lot and give it several minutes to soak in. Repeat moisturizers 3–4 times a day as needed to dry areas.

Medications

Steroid creams can be useful in treating eczema. You can buy 1 percent hydrocortisone cream over-the-counter, and use it up to four times daily on the dry spots if needed. It is safe anywhere on the body, even for babies. Stronger steroid creams are available only by prescription. Consult with your provider if you are using steroid creams for more than 1–2 weeks at a time.

Antihistamines can be helpful to decrease the itching, and prevent scratching, especially at night-time. You can give your child generic Benadryl®, loratadine, or cetirizine, or other anti-itch medications can be prescribed if needed. Dress your child lightly to keep her cool and less itchy.

Call our office if:

- Your child's eczema appears crusty, inflamed, or infected.
- Your child's rash is not improving after two weeks of above treatment.
- You have other concerns about your child's skin.

Fever

What is a fever?

Your child probably has a fever if her temperature is above 100.4°F. It doesn't matter where you take the temperature. Fever is just a sign of illness. Fevers are not dangerous and do not cause brain damage. A small percentage of children have febrile seizures, but even then, neither the fever nor the seizure cause damage to the child.

The fever is a clue that your child is sick. Fevers generally last up to four days.

The exact level of fever is not important. What is important is the comfort of your child. We want her to be drinking well, urinating at least three times a day, and having alert periods throughout the day.

For a baby less than 8 weeks old, always call your provider or seek care immediately for a fever over 100.4°F.

What can you do?

IF SHE HAS A FEVER AND IS UNCOMFORTABLE, DRESS HER LIGHTLY. Do not bundle her up. You can wipe her forehead or neck with a lukewarm washcloth. If your child smiles, plays and drinks well, you do not need to worry about the fever. If your child is sleeping, don't wake her up to give her medication. If the fever is high enough to need medication, she will awaken. If she gets chilled, then wrap her up until she feels comfortable.

YOU CAN GIVE HER ACETAMINOPHEN OR IBUPROFEN FOR COMFORT. Always measure medication with the syringe that comes with it. Do not give a child aspirin unless you've been told to by your provider. You do not need to take her temperature after giving the medicine. It does not matter how much her temperature comes down; what matters is that she seems more comfortable. Ibuprofen should NOT be given to infants less than 6 months old.

TAKING YOUR CHILD'S TEMPERATURE ONCE A DAY WHILE SHE'S SICK IS PLENTY. That way you'll know when the fever is gone.

ENCOURAGE EXTRA FLUIDS. The body loses fluids during fevers because of sweating. Encourage your child to drink extra fluids, but do not force her to drink.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- Your child is less than two months old and has a fever.
- The fever is over 105°F.
- Your child cries if you touch her or move her.
- Your child's neck is stiff.
- Any purple spots are present on the skin.
- Breathing is difficult and is not better after clearing the nose.
- Your child is unable to swallow anything and is drooling saliva.
- Your child looks or acts very sick (if possible, check your child's appearance one hour after she has taken acetaminophen or ibuprofen).

Call within 24 hours if:

- The fever is 104° to 105°F, especially if your child is less than two years old.
- Burning or pain occurs with urination.

Call during regular office hours if:

- Your child has had a fever for more than 72 hours that is not starting to come down.
- The fever went away for more than 24 hours and then returned.
- Your child has a history of febrile seizures.
- You have other questions or concerns.

Fever: Myths and Facts

Misconceptions about the dangers of fever are commonplace. Unwarranted fears about harmful side effects from fever cause lost sleep and unnecessary stress for many parents. Let the following facts help you put fever into perspective:

MYTH: All fevers are bad for children.

FACT: Fevers turn on the body's immune system. Fevers are one of the body's protective mechanisms. Most fevers are a sign that the body is working to fight infection.

MYTH: Fevers cause brain damage or fevers over 104°F are dangerous.

FACT: Fevers with infections don't cause brain damage. Only body temperatures over 108°F can cause brain damage. The body

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Fever: Myths and Facts *continued*

temperature goes this high only with high environmental temperatures (for example, if a child is confined in a closed car in hot weather).

MYTH: Febrile seizures are harmful.

FACT: Febrile seizures are scary to watch, but they usually stop within five minutes. They cause no permanent harm. Approximately 4 percent of children have a febrile seizures.

MYTH: All fevers need to be treated with fever medicine.

FACT: Fevers need to be treated only if they cause discomfort. Often this occurs with a fever over 102°F or 103°F.

MYTH: With treatment, fevers should come down to normal.

FACT: With treatment, fevers usually come down 2° or 3°F.

MYTH: If the fever doesn't come down (if you can't "break the fever"), the cause is serious.

FACT: Fevers that don't respond to fever medicine can be caused by viruses or bacteria. Whether the medicine works or not doesn't relate to the seriousness of the infection.

MYTH: If the fever is high, the cause is serious.

FACT: If the fever is high, the cause may or may not be serious. If your child looks very sick, the cause is more likely to be serious.

MYTH: The exact number of the temperature is very important.

FACT: How your child looks is what's important, not the exact temperature.

Fifth Disease *erythema infectiosum*

What is fifth disease?

Fifth disease was so named because it was the fifth pink-red infectious rash to be described by doctors.

With fifth disease:

- Your child has a bright red or rosy rash on both cheeks for 1–3 days ("slapped cheek" appearance).
- The rash on the cheeks is followed by a pink lacelike or netlike rash on the arms and legs (mainly on the thighs and upper arms).
- The "lacy" rash may come and go several times for weeks.
- Your child has a low-grade fever or no fever at all.

What is the cause?

Fifth disease is caused by a virus called human parvovirus B19.

How long does it last?

This is a very mild disease with either no symptoms or a slight runny nose and sore throat. The lacelike rash may come and go for weeks, especially after warm baths, exercise, and sun exposure.

How can I take care of my child?

No treatment is necessary. This distinctive rash is harmless and causes no symptoms that need treatment.

Is there a risk to pregnant women?

Yes. If a pregnant woman is exposed to a child with fifth disease, she should see her obstetrician. An antibody test will be done to see if the mother already had the disease and is therefore protected.

When is it most contagious?

Children will come down with the rash 10–14 days after they have been exposed to the virus. The disease is contagious during the week before the rash begins. Therefore, exposed children should try to avoid contact with pregnant women, but that can be difficult. Once a child has the bright red or lacy rash, he is no longer considered contagious and does not need to stay home from daycare or school.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child develops a fever for more than three days.
- You have other concerns or questions.

Hand, Foot and Mouth Disease

Cause

Hand, foot and mouth disease is caused by coxsackie virus. It has no relationship to hoof and mouth disease of cattle.

Symptoms

- Small, painful ulcers in the mouth.
- Small water blisters or red spots located on the palms and soles, and on the webs between the fingers and toes.
- Five or fewer blisters per hand or foot.
- Sometimes, small blisters or red spots on the buttocks, or sometimes elsewhere on the body.
- Low-grade fever between 100° and 102°F (37.8° and 38.9°C).
- Mainly occurs in children age 6 months to 4 years.

Expected course

The fever and discomfort are usually gone by day three or four. The mouth ulcers resolve in seven days, but the rash on the hands and feet can last 10 days. The only complication seen with any frequency is dehydration from refusing fluids.

Home care

- **ANTACID SOLUTION FOR PAIN RELIEF:** For very young children, put 1/2 teaspoon antacid solution in the front of the mouth four times a day after meals. Children over age 4 can use one teaspoon of an antacid solution as a mouthwash after meals.
- **DIET:** Offer a soft diet. Use a cup instead of a bottle to give fluids to very young children. Cold drinks, milkshakes and popsicles are good choices. Avoid citrus, salty or spicy foods.
- **MEDICATION:** Give acetaminophen or ibuprofen for severe mouth pain or fever.
- **CONTAGIOUSNESS:** Hand, foot and mouth disease is quite contagious. Usually some of your child's playmates will develop it at about the same time. The incubation period after contact is 3–6 days. Because the spread of infection is extremely difficult to prevent and the condition is harmless, these children do not need to be isolated. They can return to daycare or school when the fever returns to normal. While most children are contagious from two days before to two days after the rash, avoiding other children is unnecessary.

When should I call my child's healthcare provider?

Call our office IMMEDIATELY if:

- Your child has not urinated for more than 8 hours.
- Your child starts acting very sick.

Call during office hours if:

- The fever lasts more than four days.
- You have other concerns or questions.

Head Injury

What is a head injury?

Every child sooner or later strikes his head. Falls are especially common when your child is learning to walk. Most bruises occur on the forehead. Sometimes black eyes appear three days later because the bruising spreads downward by gravity. Your child may also have a cut, scrape, bruise or swelling on the scalp. Those of most concern result in unconsciousness, confusion or amnesia.

How long does it last?

Most head injuries are simply a scalp injury. Big lumps can occur with minor injuries because the blood supply to the scalp is so plentiful. For the same reason, small cuts on the head may bleed a lot. Only 1–2 percent of injured children get a skull fracture. Usually there are no associated symptoms except for a headache at the site where the head was hit.

How can I take care of my child?

- **WOUND CARE:** If there is a scrape, wash it off with soap and water. Then apply pressure with a clean cloth for 10 minutes to stop any bleeding. Apply antibiotic ointment. For swelling, apply ice for 20 minutes.
- **REST:** Encourage your child to lie down and rest until all symptoms have cleared (or at least two hours). Your child can be allowed to sleep; trying to keep your child awake continuously is unnecessary. Just have him sleep nearby so you can periodically check on him.

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Head Injury *continued*

- **MEDICATION:** Give acetaminophen or ibuprofen for headache or pain.
- **DIET:** Only give clear fluids until your child has gone two hours without vomiting. (Vomiting is common after head injuries.) If vomiting occurs three or more times, you should call your healthcare provider.
- **SPECIAL PRECAUTIONS AND AWAKENING:** Although your child is probably fine, close observation for 1–2 days will ensure that no serious complication is missed. There is no reason to awaken your child during the night after a head injury.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- Your child loses consciousness.
- The skin is split open and might need stitches.
- The headache becomes severe.
- Vomiting occurs three or more times.
- Your child's vision becomes blurred or double.
- Your child becomes difficult to awaken or confused.
- Walking or talking becomes difficult.
- Your child's neurological condition worsens in any other way.

Head Lice: Prevention and Treatment

Facts of lice

- Head lice do not transmit disease.
- Head lice need human blood to survive.
- Head lice prefer clean hair, but will get on anyone: young, old, rich, poor, clean, dirty.
- Head lice don't fly, hop or jump—they crawl.
- Head lice do not live on pets or other animals.

Lice words defined:

- A louse: one lice bug
- Lice: more than one louse
- Nit: a louse egg
- Nymph: a young louse

Life of a louse

Lice lay their eggs, called nits, onto the hair close to the head. They create a glue that firmly holds the nits or eggs onto the hair. The nits or eggs can be clear, white, yellow, brown or gray. It takes about a week for the nits or eggs to hatch. Head lice are clear in color when they hatch.

It takes about 7–10 days for a newborn louse to become an adult. At this point she can begin laying eggs. One louse can lay 6–8 eggs or nits a day for 9–10 days.

Adult head lice are reddish-brown in color. Lice have six legs with claws to help hold onto the hair. Adult lice are about the size of a sesame seed.

The total life span of a louse beginning with the egg or nit is about 25–30 days.

How lice spread

- Lice spread through head to head contact.
- Lice may spread when personal items are shared.

How to prevent head lice infestations

- Don't share items that have been in close contact with the head. A louse might be hiding in hats, coats, combs, brushes, barrettes, helmets or pillows, especially if they were recently used.

Checking for lice

- Check your child's head for lice if your child is scratching his head more than usual.
- Lice and lice eggs (nits) are very small, so use a bright light.

Here are a few pointers to help you identify nits

- Nits are hard to remove from your hair and are glued to the hair shaft at an angle.
- Nits feel like little grains of sand stuck to the hair, so you may feel them even if you can't see them.
- Dandruff can be flicked away easily with your finger. NITS CAN'T!
- Nits are tiny and can be clear, white, yellowish, brown or sometimes gray. Dandruff is usually larger and white. Nits may vary in size, but are always the same oval shape.

- Nits are usually laid close (1/8–3/16") to the scalp and most often found around the ears and along the nape of the neck. However, eggs found further away from the scalp are not always dead or empty. They still might hatch.

If you find nits or lice

You can buy lice medicine (pediculocide) over-the-counter. Pyrethrin and permethrin are available to treat head lice, under brand names Rid®, Nix® and others. DSHS will usually pay for these treatments. You'll need a metal fine-tooth comb. Follow the directions on the package carefully. You may repeat this treatment once if lice are not gone after 1-2 weeks, but do not use more than that without consulting your provider.

Combing:

Head lice and nits may be removed by combing with a special lice comb every day for three weeks.

What about nit-picking?

When you see a nit that won't come off the hair with a comb, use your fingernails to slide the nits off the hair. That is called nit-picking. Nit-picking is part of the combing process.

Cleaning household items to get rid of lice

Cleaning clothes, the house and household items is not as important as you might think. Lice cannot live more than two days off of a head. There is no need to clean every nook and cranny. If lice return, it is usually because a louse or nit was missed during combing, or because your child was exposed again.

Pets cannot get head lice. Don't use lice pesticides on your pets.

Suggested household cleaning:

Clean items used by people with lice during the two days before you began lice treatment.

- Wash sheets, pillow cases, towels and clothing. Use hot water (130°F) and the hot dryer setting for 30 minutes.
- Things that can't be washed can be sealed in a plastic bag for two weeks or dry cleaned: coats, hats, helmets, scarves, stuffed animals, pillows and comforters.
- Wash brushes, combs, barrettes and other hair holders thoroughly with hot (130°F) soapy water.
- Vacuum the floor, furniture, car seats and headrests used by the person with lice.

Additional help

- Your child's school nurse
- Your healthcare provider
- **Snohomish Health District:** 425-339-5259
- **National Pediculosis Association:** headlice.org/kids
- **Washington State Department of Health:** doh.wa.gov/Publications.aspx
- **U.S. Environmental Protection Agency, Integrated Pest Management for Schools:** A How-To-Manual. Chapter II: IPM for Head Lice in Schools: epa.gov (on site search, type in: IPM for schools)
- **U.S. Food and Drug Administration:** fda.gov (on site search, type in: head lice)
- Call our office for a "Lice Aren't Nice" booklet with all the information you'll need.

The purpose of this chapter is to give you the most current information about head lice. Descriptions of brand name products are for identification only and do not constitute endorsement by the Snohomish Health District, even when the advantages of one product over another is described. Details are provided for your information only.

Hives

What are hives?

Hives are a very itchy rash, sometimes caused by an allergic reaction. Hives look like raised pink spots with pale centers on the skin. The spots range from 1/2 inch to several inches wide. The spots may be different shapes. The spots rapidly and repeatedly change in location, size and shape.

What is the cause?

Widespread hives can be an allergic reaction to a food, medicine or insect bite, or they can be caused by a viral infection. Often the cause is not found. Hives are not contagious.

How long do they last?

More than 10 percent of children get hives. Most children who develop hives have them only once. The hives come and go for 3–5 days and then mysteriously disappear.

How can I take care of my child?

If your child feels fine, you don't need to do anything.

Antihistamine medicine

The best drug for bothersome hives is an antihistamine. An antihistamine won't cure the hives, but it may reduce their number and relieve itching. Generic Benadryl, loratadine and cetirizine are available without a prescription.

Itching

Apply a cool cloth to relieve itching. Dress lightly.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- Breathing or swallowing becomes difficult.
- There is swelling of lips or tongue.
- Your child starts acting very sick.

Call during office hours if:

- The hives last more than one week.
- You have other concerns or questions.

Nosebleeds *epistaxis*

Nosebleeds (epistaxis) are very common throughout childhood. They are usually caused by dryness of the nasal lining plus the normal rubbing and picking that all children do when the nose becomes blocked. Vigorous nose blowing can also cause bleeding. All of these behaviors are increased in children with nasal allergies.

Home care

- **Lean Forward and Spit Out Any Blood.** Have your child sit up and lean forward so he does not have to swallow the blood. Have a basin available so he can spit out any blood that drains into his throat. Blow his nose free of any large clots that might interfere with applying pressure.
- **Squeeze the Soft Part of the Nose.** Tightly pinch the soft parts of the nose against the center wall for about 10 minutes without letting go. If the bleeding continues, you may not be pressing on the right spot.

  Swallowed blood is irritating to the stomach. Don't be surprised if it is vomited up.

Prevention

- A small amount of nasal saline gel or petroleum jelly applied 2–4 times each day inside the nose is often helpful for relieving dryness and irritation.
- Increase the humidity in the room at night by using a humidifier.

Call our office during regular hours if:

- Nosebleeds occur daily even after petroleum jelly and humidification are used
- Bleeding has not stopped after one hour of pressure
- It is a large volume of blood, greater than one ounce
- You have other concerns or questions

Obesity

Obesity has become a serious health problem in America. About two-thirds of adults are obese or overweight, and a larger percentage of children than ever before are obese.

How is obesity defined?

We measure your child's height and weight at every well-child exam, and then calculate her BMI, or body mass index, to help assess if she's maintaining a healthy weight. A healthy BMI is between the 5th and 85th percentiles for your child's age and sex. A child whose BMI is over the 85th percentile is overweight, and a child over the 95th percentile is considered obese.

What causes obesity?

Body weight is dependent on a complex interplay of genetics, energy intake (what we eat) and energy output (our activity). Some children may stay slender without any special effort, while others will require careful monitoring of eating, exercise and screen time, to maintain a healthy weight.

What are the consequences of obesity?

As childhood obesity has increased dramatically in our country, we have begun to see children developing health problems that are associated with being overweight. Associated health problems include type 2 diabetes, heart disease, high cholesterol, high blood pressure, asthma, sleep apnea, joint problems and psychological problems.

Our eating and activity habits are generally learned during childhood. Parents are the most important role models for children, so it is important that a family learn healthy eating and activity habits together.

How can obesity be prevented?

Follow these principles of healthy eating:

- Set a routine schedule of three balanced meals and two healthy snacks per day.
- Have all meals in the kitchen or dining room, with no TV. Eat all meals sitting down.
- Eat something healthy for breakfast EVERY morning.
- Serve fruits and vegetables at every meal. Aim for a minimum of five per day and more than one choice per meal.
- Choose whole grain and high fiber products.
- Choose lean meats, poultry, fish, lentils, beans and low-fat dairy products for protein.
- Have only healthy snacks in the house. Don't buy junk food for home—your child will get it elsewhere.
- Limit fast foods, juice, soft drinks and sports drinks. Drink water or skim milk.
- Offer age appropriate portion sizes. Most parents are surprised to know that a good estimate of serving size is one tablespoon per year of age. For a 4-year-old, this is only a one-quarter cup.

Parents can also help in these ways

- Let children get involved with food choices and preparation as they are developmentally able and interested. Learning good choices takes practice, and food preparation can be a fun activity for a child.
- Parents have control over the choices of foods available, but children have control over what and how much they eat. While it may be tempting to engage in food fights it is never successful and often causes long-lasting, unhealthy food associations.
- Praise your child for good choices in eating and exercise. Never shame your child about weight, diet or activity.
- Help your child develop a positive relationship with food. Food is needed for nourishment and normal growth and development. It should not be used for emotional consolation; your child needs a caring adult, not food, for comfort.
- Avoid making some foods taboo. There are some foods that are better for bodies than others, but foods are not good or bad. We all like our favorite food sometimes; it's just not the basis of our daily diet. For families that have dessert, remember it is part of a meal and not a reward for behavior.
- Make meals fun! Strive to have at least one family meal per day to connect with family members and enjoy their company. Turn off the TV, talk to each other, tell jokes!

Follow these principles of healthy activity

- Limit all screen time (TV, DVDs, computer, video games) to 1–2 hours per day MAX.
- Limit screen time to common rooms of the home, not in the bedroom.
- Children under 2 years of age should be discouraged from watching any TV to allow healthy brain development.

Obesity *continued*

- All children and their parents should have a minimum of 60 minutes of physical activity per day. This does not need to be continuous or structured, but should be fun. Plan family activities such as walks, hikes, biking, house and yard projects or outings to parks.
- Consider organized sports as children get older or classes in an activity the child enjoys such as gymnastics, swimming, dance or martial arts.
- Remember 5–2–1–0: every day, include five servings of fruits and vegetables, limit screen time to two hours or less, include one hour or more of physical activity, and limit sugary drinks to zero.

If you believe your child is overweight

Schedule an appointment with your doctor or nurse practitioner to discuss a healthy weight plan for your child. Call your local YMCA and ask about healthy weight programs for children.

More information

Books:

A Parent's Guide to Childhood Obesity. A Road Map to Health. American Academy of Pediatrics; Sandra G. Hassink, MD, FAAP, Editor in Chief.

Food Fights. Winning the Nutritional Challenges of Parenthood Armed With Insight, Humor, and a Bottle of Ketchup. Laura A. Jana MD, FAAP and Jennifer Shu, MD, FAAP.

Internet sites:

American Academy of Pediatrics (AAP.org/obesity) – Information and links to many other helpful sites

Center for Disease Control (CDC.gov/obesity) – Click on Obesity and Overweight: Tips for Parents. Practical information and links to many other helpful sites.

We Can! (WeCan.nhlbi.nih.com) – National program for parents and caregivers with practical tips for helping children 8 to 13 years of age.

ChooseMyPlate.gov – Nutritional information and tips.

FruitsandVeggiesMatter.gov – Recipes and information about how to use fruits and vegetables.

How to Avoid Portion Size Pitfalls (cdc.gov/healthyweight/healthy_eating/portion_size.html) – Center for Disease Control site and game.

Roseola

What is roseola?

Roseola is a viral illness caused by the human herpesvirus-6. Roseola is common in children between 6 months and 3 years old. Your child may have roseola if:

- Your child has a fine pink rash, mostly on middle part of the body.
- Your child had a high fever 2–4 days before the rash appeared. When the rash appeared, your child's fever went away.
- Your child was only a little sick during the time with fever and acts fine now.

How long does it last?

The rash lasts one or two days, followed by complete recovery. Some children have three days of fever without a rash.

How can I take care of my child?

No particular treatment is necessary. Roseola can be spread to another child until the rash is gone. Other children of this age who have been with your child may come down with roseola in about 12 days.

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- The spots become purple or blood colored.
- Your child starts to act very sick.

Call during office hours if:

- The rash lasts more than three days.
- The fever lasts more than four days.
- You have other questions or concerns.

Spitting Up

Spitting up is a common and normal occurrence in infants and does not usually need treatment. Spitting up is the effortless spitting up (reflux) of 1 or 2 mouthfuls of stomach contents. Smaller amounts often occur with burping ("wet burps"). Larger amounts can occur after overfeeding. It is usually seen during or shortly after feedings. It occurs mainly in children under one year of age and begins in the first weeks of life. More than half of all infants will have some spitting up.

Why does it happen?

- Poor closure of the valve at the upper end of the stomach
- A shorter esophagus means that it is easier for contents in the stomach to travel back up to the mouth
- Babies spend a lot of time lying down which also makes it easier for stomach contents to come back up
- Spitting up can occur because of overfeeding

What can you do to help with symptoms?

Usually, nothing needs to be done. Spitting up can be normal. If it is not causing discomfort, then no treatment is needed. Symptoms will improve with age, usually after 6 months old.

- You can try giving smaller amounts at each feeding
- Burp more frequently during feedings
- Keep your baby upright for 20-30 minutes after feeding
- Decrease use of pacifier because this can increase the amount of swallowed air in the stomach

When should you be worried?

- If your baby chokes on spit up milk
- If he or she has poor weight gain
- If vomiting is projectile or forceful
- If baby appears in pain
- If there is diarrhea
- If the baby is acting sick

During the first month of life, newborns with true vomiting (more than half of the feeding) need to be seen immediately because the causes can be serious. Therefore, it's important to distinguish between reflux and true vomiting.

When to Call Your Doctor for Spitting Up (Reflux)

Call immediately (night or day) if

- Your child looks or acts very sick
- There is blood in the spit up
- Your baby choked on milk and turned bluish or became limp
- Your child is under 1 month old and looks or acts abnormal in any way

Call during weekday hours if

- You think your child needs to be seen
- Chokes frequently on milk
- Poor weight gain
- Frequent unexplained fussiness
- Spitting up is becoming worse (e.g. increased amount)
- You have other questions or concerns

Staph Infections

Staphylococcus aureus is a bacterium that is commonly carried on the skin or in the nose of healthy people. Approximately 30 percent of the population are colonized (the bacteria is present, but without infection) with staph bacteria. Staph bacteria can cause skin infections which are usually minor. These infections can be treated with topical antibiotics. However, staph bacteria can also cause serious infections such as pneumonia and post surgical wound infections.

Treatment

Most staph infections respond well to treatment with antibiotics. However, some staph infections are resistant to common antibiotics. These infections are known as MRSA (methicillin resistant staph aureus). MRSA can occur in hospitalized patients and can also be acquired outside of the hospital. MRSA can also cause community based infections occurring in the form of a boil or pimple. Sometimes these can cause large abscesses or blood stream infections.

Prevention

Staph infections can be partly prevented by good hygiene. It is important to keep your hands clean by using soap and water or alcohol based hand sanitizers when exposed to someone with a skin infection. Keep cuts clean and covered until healed. Avoid contact with other people's wounds. Don't share razors and towels with others. If you think you have a staph infection, call your provider's office.

Treatment

Keep wounds covered to prevent spread. Infections may need to be treated with antibiotics or drainage.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child has pimples or sores that are red, painful and not going away after a few days.
- Your child has had MRSA in the past and develops new sores.

Teething

What is teething?

Teething is the normal process of new teeth working their way through the gums. Your baby's first tooth may appear any time between the time he is 3 months to 1 year old. Most children have completely painless teething. The only symptoms are increased saliva, drooling and a desire to chew on things. Occasionally, teething can cause a low-grade fever, but not a fever of over 101°F.

How can I take care of my child?

Most babies need no special care while they're teething. Some babies like a cold teething ring or cold cloth to chew on. It is OK to use acetaminophen as needed for discomfort. Pain medications that you rub onto the gums generally do not help and can sometimes be harmful.

Cleaning the teeth

Never let your baby fall asleep with a bottle. Start brushing teeth with a soft toothbrush as soon as teeth come in. Brush twice daily and use a rice sized amount of fluoride toothpaste. Make an appointment with a dentist by age one.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child develops a fever over 101°F.
- Your child develops crying that doesn't have a cause.
- You have other questions or concerns.

Tummy Time

The American Academy of Pediatrics recommends that babies play on their tummies. Time on the tummy helps babies develop the muscle strength to hold the head up and helps the eyes to work together. Babies need to push with their hands against a firm surface to help develop the strength to manipulate toys and crayons later. In addition, a variety of positions will help to avoid problems such as neck muscle tightness and flat spots on the head.

How much tummy time

- Begin on their first day home from the hospital. Play and interact with the baby while he is awake and on the tummy 2–3 times each day for a short period of time (2–5 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 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.

Points to consider

- Time spent in a car seat is wasted time unless during transportation where straps provide safety.
- Playing in all positions is important before 3 months; on back, on belly and on sides when directly supervised.
- Sleep position should always be on their back for SIDS prevention, until approximately 6 months when the baby can change positions independently.

Ideas for tummy time

- **Tummy time is for babies who are awake and being watched.** Babies need this to develop strong muscles.
- Some babies may not like tummy time at first. Place yourself or a toy just out of the baby's reach during playtime to get him to reach for you or the toy.
- 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.
- 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.
- While sitting, place the baby on his tummy while on your lap, this works well for burping too.

Vomiting

Cause

Most vomiting is caused by a viral infection of the lining of the stomach or by eating something which disagrees with your child. Often, a child whose vomiting is caused by a virus also has diarrhea. Sometimes children vomit from coughing hard.

Expected course

The vomiting usually decreases or stops in 6–24 hours. Changes in the diet usually speed recovery. If your child has diarrhea, it may continue for up to two weeks.

Home care for vomiting

- **Offer small amounts of clear fluids for 6–8 hours (no solid food):** Offer clear fluids (not milk) in small amounts until 6–8 hours have passed without vomiting. For infants, give Pedialyte or an electrolyte solution. For older kids, you can use water, Pedialyte, diluted apple juice, diluted white grape juice, diluted Gatorade®, flat 7-Up® or Jell-O®.

  Start with one teaspoon to one tablespoon of the clear fluid every 10 minutes. If your child vomits using this treatment, rest the stomach completely for one hour and then start over but with smaller amounts. This one-swallow-at-a-time approach rarely fails.
- **Offer bland foods after 6–8 hours without vomiting:** After 6–8 hours without vomiting, your child can gradually return to a normal diet.

  Older children can start with such foods as saltine crackers, bread, bland soups, rice and mashed potatoes. Infants can start back on formula.

  Usually your child can be back on a normal diet within 24 hours after recovery from vomiting.
- **Diet for breast-fed babies:** The key to treatment is providing breast milk in smaller amounts than usual. If your baby vomits occasionally, make no changes. If your baby vomits repeatedly, continue breast-feeding but nurse for a shorter period of time, every 1–2 hours.

As soon as 6–8 hours have passed without significant vomiting, return to normal nursing. Pedialyte is rarely needed for breast-fed babies. If your baby is urinating less frequently than normal, you can offer the baby Pedialyte between breast-feedings for a short time (6–24 hours).

- **Formula-fed babies:** If the vomiting is infrequent, it is okay to feed on through. If it is frequent (more than 3–4 times) stop the formula and any solids and give Pedialyte only in small amounts frequently as tolerated until the vomiting has decreased.
- **Medicines:** Do not give your child any medicines by mouth for 6–8 hours. Oral medicines can irritate the stomach and make vomiting worse. If your child is uncomfortable from a fever of 100.4°F or greater, you can use acetaminophen suppositories. Call your provider if your child needs to continue taking a prescription medicine.
- **Common mistakes in the treatment of vomiting:** A common error is to give as much clear fluid as your child wants rather than gradually increasing the amount. This is more likely to lead to continued vomiting.
- **For children over six months of age:** It is okay to give small amounts of diluted sports drinks (such as Gatorade) instead of Pedialyte.
- **Do not use any over-the-counter medications for vomiting unless directed by your provider.**

When should I call my child's healthcare provider?

Call IMMEDIATELY if:

- Your child shows signs of dehydration (such as no urine in over 12 hours, very dry mouth, no tears when crying).
- Your child vomits up blood.
- Your child starts acting very sick.

Call during office hours if:

- The vomiting continues for more than 24 hours if your child is under 2 years or 48 hours if over age 2.
- You have other concerns or questions.

Behavior and Development:

Tips for everything from temper tantrums to toilet training

Positive Parenting for Young Children

Parenting is the hardest job you will ever have! Each of your children is unique, with her own special strengths, needs and problems. A positive style of parenting will help children learn to cope with and solve problems, make good choices and develop healthy relationships with friends and family.

A positive style of parenting will help you and your child achieve these goals in the best way possible. The following are tips, suggestions and guidelines for positive parenting.

Play

Children learn about themselves and their world through play. For children, play is the work of living! Spending just 20 minutes a day playing with your child can be the best gift you can give. The following suggestions will make your playtime effective and fun:

- Let your child choose the play activity, take the lead, and show you how to play.
- Get involved. Listen well. Avoid questioning, commanding or interrupting your child's conversation and play.
- Smile, look at and praise your child's play.

Communication

Spend a day just listening to the way you talk with your child. How many questions do you ask? How many commands do you give? How often do you criticize? How often do you praise your child? Do you sometimes just listen? Try the following strategies for improving communication:

- Use descriptive commenting. "You are putting the red block on the green block."
- Use reflective commenting. Child: "I'm making a big truck." Adult: "You ***are*** making a big truck."

Praise

We all like to please others and feel good about ourselves and our accomplishments. Praise tells your child what behavior is good. If children know what behavior is appreciated, they will be more likely to repeat the behavior. Praise should be specific and accompanied by a smile, a pleasant touch or a hug. Examples are:

- "I like the way you put your toys away! Thanks."
- "You did a good job of setting the table."
- "You drew a beautiful picture!"

Discipline

Managing a child who is out of control, non-compliant or just pushing buttons can be very difficult. Most of this behavior is attention-getting behavior. As the parent, you need to help your child see that good behavior gets attention and bad behavior does not. Your child wants your attention more than anything else. You can use that desire to achieve good behavior. Before negative behavior starts, try these tips:

- Give the child choices when appropriate. Child: "I want a cookie." Parent: "You can have a banana or a slice of cheese."
- Use positive consequences. "If you put your toys away, we'll read a story."
- Use warnings (negative consequences) effectively, sparingly and always follow through. "If you don't stop writing on the table, I'll take the crayons away."
- Most negative behavior can be ignored! Ignore whining, tantrums and smart-talking.
- Use time-outs when appropriate.

Ignoring can be difficult. Here are more tips:

- Turn your back. Do not look at, laugh at or talk to your child. Leave the room.
- Read the paper.
- Pretend you are talking on the phone.
- Have a conversation about *anything* with someone else—laugh and smile!

Help

Sometimes parents have special problems managing their children or just want to know more about child rearing. Some people or places that may be able to help are:

- Your provider or office nurse
- The Everett Clinic Center for Behavioral Health, 425-339-5453
- Parents Anonymous, 425-258-6335
- Everett Community College Family Life Program, 425-388-9300
- Child Protective Services, 425-339-3900
- Parenting Clinic, University of Washington, 206-543-8855
- Children's Hospital Resource Line, 206-987-2500
- Care Crisis Line, 425-258-4357
- Compass Health, 425-349-6200

Masturbation in Preschoolers

Masturbation is self-stimulation of the genitals for pleasure and self-comfort. Children may rub themselves with a hand or other object. During masturbation, a child usually appears dazed, flushed and preoccupied. A child may masturbate as often as several times each day or just once a week. Masturbation occurs more commonly when a child is sleepy, bored, watching television or under stress.

Cause

Occasional masturbation is a normal behavior of many toddlers and preschoolers. Up to a third of children in this age group discover masturbation while exploring their bodies. Often they continue to masturbate simply because it feels good. Some children masturbate frequently because they are unhappy about something, such as having their pacifier taken away.

Masturbation has no medical causes. Irritation in the genital area causes pain or itching; it does not cause masturbation.

Expected course

Once your child discovers masturbation, she will seldom stop doing it completely. Your child may not do it as often if any associated power struggles or unhappiness are remedied. By age 5 or 6, most children can learn some discretion and will masturbate only in private. Masturbation becomes almost universal at puberty in response to the normal surges in hormones and sexual drive.

Coming to terms with masturbation in preschoolers

- **Have realistic goals.** It is impossible to eliminate masturbation. Accept the fact that your child has learned about it and enjoys it. The only thing you can control is where she does it. A reasonable goal is to permit it in the bedroom and bathroom only. You might say to your child, "It's OK to do that in your bedroom when you're tired."
- **Ignore masturbation at naptime and bedtime.** Leave your child alone at these times and do not keep checking on her.
- **Distract your child from masturbation at other times.** First, try to distract your child with a toy or activity. If this fails, explain to your child: "I know that feels good. It's okay to do it in your room or the bathroom, but do not do it in the rest of the house or when other people are around." By the time children are 4 or 5 years old, they become sensitive to other people's feelings and understand that they should masturbate only when they are alone. Younger children may have to be sent to their rooms to masturbate.
- **Discuss this approach with your child's daycare or preschool staff.** Ask your child's caregiver or teacher to respond to your child's masturbation by first trying to distract the child. If this doesn't work, they should catch the child's attention with comments such as, "We need to have you join us now." Masturbation should be tolerated at school only at naptime.

Common mistakes

The most common mistake that parents make is to try to eliminate masturbation completely. This leads to a power struggle which the parents inevitably lose. Children should not be physically punished for masturbation, nor yelled at or lectured about it.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child continues to masturbate when other people are around.
- You suspect that your child has been taught to masturbate by someone.
- Your child tries to touch others inappropriately.
- You feel your child is unhappy.
- You cannot accept any masturbation by your child.
- You have other questions or concerns.

Sleep Problems

How do I prevent sleep problems?

Parents want their children to go to bed without resistance and to sleep through the night. They look forward to a time when they can again have seven or eight hours of uninterrupted sleep. Newborns sleep only 3-4 hours at a stretch. Older infants may awaken once in the night. Babies over 6 months can generally learn to sleep through the night.

Consider the following guidelines if you want to teach your baby that nighttime is a special time for sleeping, that her crib is where she stays at night and that she can put herself back to sleep. It is far easier to prevent sleep problems before 6 months of age than it is to treat them later.

Newborns:

- **Hold or comfort your baby for fussy crying during the first three months.** All new babies cry some during the day and night. If your baby cries excessively, the cause may be colic. Always respond to a crying baby. Gentle rocking and cuddling seem to help the most. Babies can't be spoiled during the first 3 or 4 months of life. But even colicky babies have a few times each day when they are drowsy and not crying. On these occasions, place your child in the crib and let her learn to comfort himself and put himself to sleep. Crying is the only form of communication newborns have. Crying does not always mean your baby is hungry. She may be tired, bored, lonely or too hot. Hold your baby at these times or put her to bed. Don't let feeding become a pacifier.
- **Make middle-of-the-night feedings brief and boring.** You want your baby to think of nighttime as a special time for sleeping. When she awakens at night for feedings, don't turn on the lights, talk to her or rock her. Feed her quickly and quietly.
- **Don't awaken your infant to change diapers during the night.** The exceptions to this rule are diapers soiled with bowel movements or times when you are treating a bad diaper rash. If you must change your child, use as little light as possible (for example, a flashlight), do it quietly and don't provide any entertainment.

Infants:

- **Always place your baby on her back to sleep.** It's safest to place her in a crib or bassinet. The crib should have no soft pillows, blankets or toys, and it's best not to use crib bumpers. Do no place her on her side because she could roll to her stomach from that position. These recommendations minimize the chance of SIDS, sudden infant death syndrome, or "crib death." Once she learns to roll over, around 4–6 months old, still put her to sleep on her back, but if she rolls you can leave her sleeping on her stomach.
- **Try placing her in her crib when she's drowsy but still awake.** It often takes 20 minutes of restlessness for a baby to fall asleep. She may fuss or even cry a bit, but learning to put herself to sleep is an important skill for your baby. It's best to do the same at nap time. It's best not to let her fall asleep on the couch or in your bed, moving her when she's fast asleep. She's much more likely to awaken frequently at night if she hasn't put herself to sleep in her crib.
- **It's best not to let your baby sleep in the same bed with you.** There's an increased chance of SIDS with co-sleeping, and it may be harder to teach her to sleep by herself when she's older. However, room sharing for the first 6 months is recommended.

Toddlers:

- **Establish a pleasant and predictable bedtime ritual.** Bedtime rituals, which can start in the early months, become very important to a child by 1–year of age. Children need a familiar routine. Finish the bedtime ritual before your child falls asleep.
- **Once put to bed, your child should stay there.** Some older infants have temper tantrums at bedtime. They may protest about bedtime or even refuse to lie down. You should ignore these protests and leave the room. You can ignore any ongoing questions or demands your child makes and enforce the rule that your child can't leave the bedroom. If your child comes out, return her quickly to the bedroom and avoid any conversation. If you respond to her protests in this way every time, she will learn not to try to prolong bedtime.
- **Don't worry about the amount of sleep your child is getting.** Different people need different amounts of sleep at different ages. The best way you can know that your child is getting enough sleep is that she is not tired during the day.

  Naps are important to young children. Around one year your baby will transition from two naps a day to one. She may be somewhat crabby initially until her body gets accustomed to one nap. Around 3–5 years of age, most children give up their naps entirely. It's helpful to continue establishing this afternoon time as "quiet time" even if she doesn't sleep. Your child gets some rest and you get a bit of free time.

Eliminating Nighttime Feedings *Trained Night Feeder*

For babies over 4 months old

When should babies be fed at night?

From birth to the age of 2 months, most babies awaken twice each night for feedings. Between the ages of 3 and 6 months, most babies need 1–2 feedings in the middle of the night. Many babies go through a brief growth spurt at 6 months and wake up once in the night to eat. This lasts only a few weeks, and all babies 7 months or older can learn to sleep through the night without being fed.

Why does my baby wake at night to be fed?

Some common reasons that babies older than 4 months wake up at night to be fed, and should be avoided, include:

- **Nursing or bottle-feeding the baby until asleep.** If the last memory before sleep is sucking the breast or bottle, the bottle or breast becomes the baby's security object. The child does not learn to comfort himself and fall asleep without the breast or bottle. Therefore, when the child normally wakes up at night, the child has the habit of not being able to go back to sleep without feeding. Being brought to the parents' bed for a feeding makes the problem far worse.
- **Leaving a bottle in the bed.** Periodically during the night the child sucks on a bottle. When it becomes empty, the child awakens fully and cries for a refill. Bottles in bed, unless they contain only water, also can lead to severe tooth decay.
- **Feeding often during the day.** Some parents misinterpret "demand feedings" to mean that they should feed the baby every time he cries. This misunderstanding can lead to feeding the baby every 30–60 minutes. A pattern of feeding every hour or so is called grazing.

How can I help my child?

Try the following suggestions if your child is over 4 months old and wakes up and cries one or more times at night to be fed.

- **At naps and bedtime, place your baby in the crib drowsy but awake.** When your baby starts to act sleepy, place her in the crib. If your baby is very fussy, rock her until she settles down or is almost asleep, but stop before she's fully asleep. Your baby's last waking memory needs to be of the crib and mattress, not of the breast or bottle. She needs to learn to put herself to sleep. Your baby needs to develop this skill so she can put herself to sleep when she wakes up at night.
- **If your baby is crying at bedtime or naptime, visit your baby briefly every 5–15 minutes.** Visit your baby before he becomes too upset. Gradually lengthen the time between your visits. Make your visits brief and boring but supportive. Don't stay in the room longer than one minute. Don't turn on the lights. Act sleepy. Whisper, "Shhh, everyone's sleeping." Do not remove your child from the crib. Do not feed, rock or play with your baby or bring her to your bed. This brief contact will not reward your baby enough for her to want to continue the behavior. Once you put your child in the crib, do not remove her. You may also discuss the cry-it-out method with your provider.

Other helpful hints for sleep problems:

- **Move the crib to another room.** If the crib is in your bedroom, move it to a separate room. If this is impossible, put up a screen or barrier so your baby can't see you when she wakes up.
- **Don't change wet diapers during the night.** Change the diaper only if it is soiled or you are treating a bad diaper rash. If you must change your child's diaper, use as little light as possible (for example, a flashlight), do it quickly and don't provide any entertainment.
- **If your child is standing up in the crib at bedtime, try to get your child to settle down and lie down.** If she refuses or pulls herself back up, leave her that way. She can lie down without your help. Encouraging your child to lie down soon becomes a game.

When should I call my child's healthcare provider?

Call during office hours if:

- You think the crying is because of pain, fever or vomiting.
- Your child acts fearful.
- Someone in your family cannot tolerate the crying.
- You have other questions or concerns.

Nightmares

Nightmares are scary dreams that awaken a child. Occasional bad dreams are normal at all ages after about 6 months of age. When infants have a nightmare, they cry and scream until someone comes to them. When preschoolers have a nightmare, they usually cry and run into their parents' bedroom. Older children begin to understand what a nightmare is and put themselves back to sleep without bothering their parents.

Cause

Dreams help the mind process complicated happenings or information. The content of nightmares usually relates to developmental challenges: toddlers have nightmares about separation from their parents; preschoolers, about monsters or the dark; and school-age children, about death or real dangers. Frequent nightmares may be caused by violent TV shows or movies.

Treatment suggestions

- **Reassure and cuddle your child.** Explain to your child that she was having a bad dream. Sit on the bed until your child is calm. Most children return to sleep fairly quickly.
- **Offer a night-light.** Offer to leave the bedroom door open and to provide a night-light.
- **Help your child talk about the bad dreams during the day.** Your child probably won't remember what the dream was about unless you can remind her of something she said about it when she woke up. If your child has the same bad dream over and over again, help her imagine a good ending to the bad dream. Encourage your child to use a strong person or a magic weapon to help her overcome the bad parts in the dream. You may want to help your child draw pictures of the new ending for the dream.
- **Prevention.** Avoid violent movies and disturbing TV news.

Night Terrors

Definition

- Your child is frightened, but cannot be awakened or comforted.
- Your child is agitated and may sit up or run helplessly about, possibly screaming or talking wildly.
- Your child doesn't appear to realize that you are there. Although the eyes are wide open and staring, your child looks right through you.
- Your child may mistake objects or persons in the room for dangers.
- The episode lasts from 10–30 minutes.
- Afterwards the child cannot remember the episode (amnesia).

Cause

Night terrors are a mild sleep disorder, often inherited, in which a child's sleep is disrupted by what looks like a nightmare. The child is not awake, however, cannot be soothed and does not remember the episode the next day. Night terrors generally happen 1½ to 2 hours after falling asleep. They are harmless, even though they can be scary to watch.

Expected course

Night terrors are harmless and each episode will end on its own. The problem will usually disappear by age 12 or sooner.

Treatment suggestions

- **Try to calm your child.** Your goal is to help your child return to a calm sleep. Do not try to awaken your child. Make soothing comments such as, "You are all right. You are home in your own bed. You can rest now." Speak slowly and repetitively. Such comments are usually better than silence. Some children like to have their hand held during this time, but some will pull away. Hold your child only if it seems to help your child feel better. There is no way to abruptly shorten the episode. Shaking or shouting at your child will just cause the child to be more agitated and will prolong the episode.
- **Protect your child against injury.** Gently direct your child back to bed and stay there with her until she falls back asleep.
- **Prepare babysitters or adults who supervise an overnight for these episodes.** Explain to people who care for your child what a night terror is and what to do if one happens. Understanding this will prevent them from overreacting when your child has a night terror.
- **Prevention.** Have a consistent sleep schedule. Sleep deprivation can cause night terrors. Talk with your healthcare provider about other strategies.

Temper Tantrums

A temper tantrum is an immature way of expressing anger. No matter how calm and gentle a parent you are, your child will probably throw some tantrums. Try to teach your child that temper tantrums don't work, that you don't change your mind because of them. By school age, temper tantrums should be rare. During adolescence, tantrums reappear but your teenager can be reminded that blowing up creates a bad impression and that counting to 10 can help him regain control.

Responses to temper tantrums

Overall, praise your child when he controls his temper, verbally expresses his anger and is cooperative. Be a good model by staying calm and not screaming or having adult tantrums. Avoid spanking for tantrums because it conveys to your child that you are out of control. Try using the following responses to the different types of temper tantrums.

Support and help children having frustration or fatigue related tantrums.

Children often have temper tantrums when they are frustrated with themselves. They may be frustrated because they can't put something together. Young children may be frustrated because their parents don't understand their speech. Older children may be frustrated with their inability to do their homework. At these times your child needs encouragement and a parent who listens. Say something brief that shows understanding such as "I know it's hard, but you'll get better at it. Is there something I can do to help you?" Also give praise for not giving up. Some of these tantrums can be prevented by steering your child away from tasks that he can't do well.

Children tend to have more temper tantrums when they are tired (for example, when they've missed a nap) because they are less able to cope with frustrating situations. At these times put your child to bed. Hunger can contribute to temper tantrums. If you suspect this, give your child a snack. Temper tantrums also increase during sickness.

Ignore attention-seeking or demanding-type tantrums.

Young children may throw temper tantrums to get their way. They may want to go with you rather than be left with the babysitter, want candy, want to empty a desk drawer or want to go outside in bad weather. They don't accept rules for their safety. Tantrums for attention may include whining, crying, pounding the floor or wall, slamming a door or breath-holding. As long as your child stays in one place and is not too disruptive, you can leave him alone.

If you recognize that a certain event is going to push your child over the edge, try to shift his attention to something else. However, don't give in to your child's demands. During the temper tantrum, if his behavior is harmless, ignore it completely. Once a tantrum has started, it rarely can be stopped. Let it run its course.

Move away, even to a different room, so your child no longer has an audience. Don't try to reason with your child, it will only make the tantrum worse. Simply state "I can see you're very angry. I'll leave you alone until you cool off." Let your child regain control. After the tantrum, be friendly and try to return things to normal. You can prevent some of these tantrums by saying "no" less often.

Hold children having harmful or rage-type tantrums.

If your child is totally out of control and screaming wildly, consider holding him. His loss of control probably scares him. Also hold your child when he is having tantrums that carry a danger of self-injury (such as violently throwing himself backward).

Take your child securely in your arms, tell him you know he is angry and offer him your sense of control. Hold him until you feel his body start to relax. Then let him go. This usually takes 1–3 minutes. This comforting response is rarely needed after 3 years of age.

Some children won't want you to comfort them. Hold your child only if it helps. If your child says "Go away," do so. After the tantrum subsides, your child will often want to be held briefly. This is a good way to get him back into the family activities.

Toilet Training Your Child *The Basics*

What is toilet training?

Your child is toilet trained when, without any reminders, he walks to the potty, pulls down his pants, urinates or passes a bowel movement (BM), and pulls up his pants. Some children will learn to control their bladders first. Others will start with bowel control. Both kinds of control can be worked on simultaneously. Bladder control through the night normally happens several years later than daytime control.

18–24 months:

Begin teaching about pee, poop and how the body works.

- Make changing diapers pleasant for the child so he will come to you.
- Change your child frequently so he will prefer dry diapers.
- Teach your child to come to a parent whenever he is wet or soiled.

Begin teaching abut the potty and toilet.

- Teach what the toilet and potty chair are for.
- Portray the toilet and potty chair as a privilege to use.
- Buy a floor-level type potty chair. You want your child's feet to touch the floor when he sits on the potty. This provides leverage for pushing and a sense of security. He also can get on and off whenever he wants to.
- Have your child sit on the potty chair for fun. Have your child sit on it fully clothed until he is comfortable with using it as a chair. Have your child use it while eating snacks, playing games or looking at books.

How do I toilet train my child?

- **Encourage practice runs to the potty.** A practice run (potty sit) is encouraging your child to walk to the potty and sit there with his diapers or pants off. Your child can then be told, "Try to go pee-pee in the potty." Only do practice runs when your child gives a signal that looks promising, such as a certain facial expression, grunting, holding the genital area, pulling at his pants, pacing, squatting, squirming, etc. Other good times are after naps, two hours without urinating or 20 minutes after meals. If your child is reluctant to sit on the potty, you may want to read him a story. If your child wants to get up after one minute of encouragement, let him get up. Never force your child to sit there. Never physically hold your child there. During toilet training, children need to wear clothing that's conducive to using the potty.
- **Praise or reward your child for cooperation or any success.** All cooperation with these practice sessions should be praised. For example, you might say, "You are sitting on the potty just like Mommy," or "You're trying real hard to go pee-pee in the potty." If your child urinates into the potty, he can be rewarded with treats, such as stickers, as well as praise and hugs. Although a sense of accomplishment is enough for some children, many need rewards to stay focused.
- **Change your child after accidents.** Change your child as soon as it's convenient, but respond sympathetically. Say something like, "You wanted to go pee-pee in the potty, but you went pee-pee in your pants. I know that makes you sad. You like to be dry. You'll get better at this." Then change your child into a dry diaper or training pants in as pleasant and non-angry a way as possible. Avoid physical punishment, yelling or scolding. Pressure or force can make a child completely uncooperative.
- **Introduce underpants only after your child is using the potty.**

Points of interest:

- **Length of time for toilet training.** This can range from gradual training over a period of weeks to training in a few days (usually the children in the 2–3 year range). Most children have occasional accidents once they are trained.
- **Staying dry at night.** Some children stay dry at night at the same time they are learning to control their bladder in the daytime. Other children who have a smaller or less mature bladder, need to wear diapers or pull-ups at night for some time.
- **Children who develop behavior problems during toilet training.** During toilet training, if you notice new types of problems such as eating, sleeping, temper tantrums, etc., it is possible that there is a connection with the toilet training. Try giving up toilet training for a week. If the behavior problem improves, your child was probably feeling pressured by the toilet training. Wait a few weeks before you try again and do it in a more relaxed way.
- **Children who were potty trained but then start having accidents.** This is more likely to happen if there is a change in the family (move, illness, divorce, death, newborn). Constipation can also cause accidents. Your child may also need to be evaluated for a urinary tract infection.
- **50 percent of 3-year-olds will still wet at night.** 20 percent of 6-year-olds will.

Toilet Training Your Child *continued*

What if toilet training isn't working?

There are some children who are resistant to toilet training. Your child is considered resistant if after trying to toilet train your child using the method described above:

- Your child is over 2½ years old and has a negative attitude about toilet training.
- Your child is over 3 years old and not daytime toilet trained.
- Your child won't sit on the potty or toilet.
- Your child holds back bowel movements.
- The approach described here isn't working after six months.

If your child is resistant to toilet training, ask your health care provider for ideas and information about toilet training resistance.

TV Viewing, Screen Media and Child Development

Television programs can be entertaining and educational, and in many families are a major daily activity.

For many years, however, doctors, teachers and parents have wondered what the effects of TV and other screen media are on our children. We now have excellent research evidence for many negative consequences of too much screen time.

Children who watch TV are at higher risk for obesity, more likely to be diagnosed with ADHD, and don't do as well in school. Infants and toddlers exposed to *Baby Einstein* videos have shown slower language development. Violent entertainment has clearly been linked to aggressive behavior in children.

Children sitting watching a screen are not running, playing or learning social interactions. Humans learn speech from participating in one-on-one interactions with their caregivers, not from drills on a screen. Children learn more effectively by ***doing*** than by watching. The fast pace and rapid scene changes in many programs (even Sesame Street) can encourage a short attention span. Children watching TV are exposed to almost continuous advertisements for sugary drinks and cereals, and high fat foods. Advertisers would not spend so much money on TV ads if they didn't work!

The American Academy of Pediatrics has several recommendations for parents:

- For children under 2 years of age, avoid screen media other than video-chatting and **minimal** high-quality programming.
- No more than two hours per day of screen time for children over 2 years of age, including TV, computer, smartphone and video game time.
- Take TVs out of children's bedrooms.
- Watch TV with your children—know what they are watching and talk with them about it.
- Turn the TV off during mealtimes and do not allow snacking while watching TV.
- Enjoy a family game night, evening walks or reading time with the kids instead of watching TV.

You can help prevent obesity, ADHD, sleep disorders, delayed language development and depression in your child by limiting her screen time.

The sooner you start, the easier it will be.

These good habits will last a lifetime.

Start now!

Nutrition and Eating:

Feeding your child from infancy through the toddler years

Vitamin D and Your Breastfed Baby

The facts

- Breast milk is the best source of nutrition for your baby's health.
- Vitamin D is needed to help your baby build strong bones. It is present in breast milk, but in small amounts.
- Babies and adults get vitamin D two ways: through their diet and via exposure to the sunlight by our skin.
- Studies have found that breastfed infants are at risk for developing vitamin D deficiency without vitamin supplements or adequate exposure to sunlight.
- While sunlight is a great source of vitamin D, the American Academy of Pediatrics (AAP) recommends infants less than 6 months should be kept out of direct sunlight to prevent harmful effects of ultraviolet light.
- Babies may be at risk for vitamin D deficiency if they have darker pigmented skin or if they live in an area with decreased sun exposure like the Puget Sound.
- Rarely, severe vitamin D deficiency can lead to rickets—a condition that makes babies bones very weak and can cause bowing of the legs.

What you can do to prevent vitamin D deficiency in your breastfed baby

- The AAP and your pediatrician recommend giving your breastfed baby 400 IU of vitamin D until they reach 1 year of age.
- The dose of infant multivitamins is 400 IU of vitamin D per day. You do not need a prescription for these vitamins. Examples include tri-vitamin infant drops that provide vitamin A, D and C, or Poly-Vi-Sol® drops.
- You can start giving your baby the vitamins sometime in the first two months. Alternatively, a breastfeeding mother can take 6400 IU of Vitamin D daily.
- When your baby is getting at least one liter or 33.8 ounces of formula or breast milk a day, you do not need vitamin D supplements anymore
- Read more about Vitamin D at the AAP website: aap.org.

Early Infant Feeding

Breastmilk and formula are the main source of nutrition until 1 year old. The American Academy of Pediatrics (AAP) currently recommends gradually introducing solid foods when a baby is 4–6 months old.

Your baby may take a little while to learn how to eat solids. During these months you'll still be providing the usual feedings of breast milk or formula, so don't be concerned if your baby refuses certain foods at first or doesn't seem very interested in food. It may just take some time.

Is my child ready to eat solids?

How can you tell if your baby is ready for solids? Here are a few hints:

- Is your baby's tongue-thrust reflex gone or diminished? This reflex, which prevents infants from choking on foreign objects, also causes them to push food out of their mouths.
- Can your baby support his or her own head? To eat solid food, an infant needs good head and neck control and should be able to sit up.
- Is your baby interested in food? A 6-month-old baby who stares and grabs at your food at dinnertime is clearly ready for some variety in the food department.

If your baby seems frustrated or uninterested as you're introducing solid foods, try waiting a few days or even weeks before trying again. Since solids are only a supplement at this point, breast milk and formula will still provide your baby's basic nutritional needs.

How should I start feeding my baby solids?

When your baby is ready and you have been given the OK to try solid foods, pick a time of day when your baby is not tired or cranky. Nurse or bottle feed your baby first, and offer solids about an hour later when your child is alert and content. Have your baby sit supported in your lap or in an upright infant seat. Infants who sit well, usually around 6 months, can be placed in a high chair with a safety strap.

A simple pureed/mashed fruit or vegetable, either plain or mixed with breast milk/formula, is a good first food. Because of concerns for arsenic in rice, rice cereal is probably not a good choice. If you would like to try a cereal, try oatmeal. Place the spoon near your baby's lips, and let the baby smell and taste. Don't be surprised if this first spoonful is rejected. Wait a minute and try again. Most food offered to your baby at this age will end up on the baby's chin, bib, or high-chair tray. Again, this is just an introduction.

Do not add cereal to your baby's bottle unless your child's healthcare provider instructs you to do so, as this can cause babies to become overweight and doesn't help the baby learn how to eat solid foods.

Early Infant Feeding *continued*

When introducing new foods, go slow. Introduce one food at a time and wait several days before trying something else new. This will allow you to identify foods that your baby may be sensitive to. In the beginning, you can offer these tastes once or twice a day. Many babies are having 2–3 meals per day by 9 months old.

New research has shown that giving potential allergy foods such as peanut butter, eggs, fish or wheat before 12 months of age may protect against future food allergies. Talk with your child's healthcare provider about introducing these foods. Applesauce and bananas tend to cause constipation; pureed plums, prunes and prune or pear juice diluted with water help avoid constipation.

Foods to avoid for now

Avoid all choke foods—nuts, seeds, hot dogs and raw crunchy foods (apples, broccoli, carrots, celery). Cow's milk should not be a substitute for breast milk or infant formula until 12 months of age. No honey until 12 months old due to a risk of botulism infection.

Some possible signs of food allergy or intolerance include:

- Rash
- Diarrhea
- Fussiness after eating

For more severe allergic reactions, like hives, bloody diarrhea or breathing difficulty, get medical attention right away. If your child has any type of reaction to a food, don't offer that food until you talk with your child's provider.

Tips for introducing solids

With the hectic pace of family life, most parents opt for commercially prepared baby foods. Or, you can make your own baby food by mashing up soft foods such as cooked carrots or potatoes.

At first, babies should have finely pureed single foods (just applesauce, for example, not apples and pears mixed together). After you've successfully tried individual foods, it's OK to offer a pureed mix of two foods. When your child is about 9 months old coarser, chunkier textures are going to be tolerated as he begins transitioning to a diet that includes more table foods.

You can introduce a sippy cup around 6–9 months of age, for water or diluted fruit juice if treating constipation. Serve only 100 percent fruit juice, not juice drinks or powdered drink mixes. Do not give juice in a bottle and remember to limit the amount of juice your baby drinks to less than four total ounces a day. We recommend that juice be diluted with water by at least half. Fruit juice is not much better than soda. Water is the best liquid. Drinking juice can contribute to being overweight and can cause diarrhea.

Transitional Feeding

Meal times should be happy times for you and your baby. At 9–12 months of age, your baby enjoys watching other people eat and will naturally try to imitate them. Your baby can now eat lumpier foods and will begin to show interest in feeding himself. Even babies with no teeth can handle soft foods. This exploration is typically quite messy but serves an important role in your child's overall development of self-feeding skills.

Tips for transitional feeding:

1. Finger foods are the big attraction at this age. Here are some suggestions:
   - Small, soft pieces of fruit such as banana, pear, peach
   - Soft, cooked vegetables in small pieces
   - Soft, small cubes of cheese
   - Rice
   - Soft, cooked macaroni or spaghetti
   - Tofu
2. When a baby first begins finger-feeding, he sometimes chokes. Therefore, parents need to watch closely during meal times. If your baby begins to choke while eating, allow him time to clear his own airway. However, if he cannot cough, makes no sounds or turns blue, take action to reverse the choking.
3. Initially offer a single piece of food. Let your baby feed himself. Then offer another piece. Gradually increase the number of pieces of food offered as he gains skills in self-feeding.
4. Eventually, allow your baby to take over feeding entirely.
5. When your baby has reached 12 months of age, you may switch from commercial infant formula to dairy. If breastfeeding, continue to do so; you may also offer cows milk as desired. Limit milk to 24 ounces or less—more than this amount can cause anemia.
6. Remember to offer small amounts of food and never force your baby to finish eating something he doesn't want.

Appetite Slump in Toddlers

What is an appetite slump?

Between 1 and 5 years old, it is normal for a toddler's appetite to slow down. It will probably seem like your child doesn't eat enough, is never hungry or won't eat unless you spoon-feed her yourself. As long as your child's energy level is normal and she is growing normally, your child's appetite is most likely naturally slowing down.

What is the cause?

Between 1 and 5 years of age many children normally gain only 4 or 5 pounds each year even though they probably gained 15 pounds during their first year. Children in this age range can normally go 3–4 months without any weight gain. How much a child chooses to eat is controlled by the appetite center in the brain. Kids eat as much as they need for growth and energy.

Many parents try to force their child to eat more than he needs to because they fear that his poor appetite might cause poor health or a nutritional deficiency. This is not true, however, and forced feedings actually make things worse.

What can I do to help my child?

- **PUT YOUR CHILD IN CHARGE OF HOW MUCH HE EATS AT MEALTIME.** Trust your child's appetite center. After 1 year of age, the parent's job is to offer three healthy meals and two healthy snacks a day, in the kitchen or dining room, without the TV on. The child's job is to eat whatever he wishes off the plate. This way he learns to eat when he's hungry and quit when he's full. He won't learn to eat to please a parent, eat because he's bored, or eat because the TV's on.
- **ALLOW ONE SMALL SNACK BETWEEN MEALS.** The most common reason for some children never appearing hungry is that they have so many snacks that they never become truly hungry. Offer your child no more than two small snacks of nutritious food each day, and provide them only if your child requests them. If your child is thirsty between meals, offer water. Skipping an occasional meal is harmless.
- **NEVER FEED YOUR CHILD IF HE IS CAPABLE OF FEEDING HIMSELF.** Parents of a child with a poor appetite will tend to pick up the spoon, fill it with food, smile, and try to trick the child into taking it. If your child is hungry, he will feed himself. Forced feeding is the main cause of eating power struggles.

  It is best not to spoon feed your child. He can eat finger foods by himself until he's old enough (15 months or so) to feed himself soft foods with a spoon.

  It is best not to let your child carry crackers or sippy cups around the house. This grazing can lead to obesity.

  Do not give your child a bottle, only cups.

  Do not feed your child in front of the TV. This can lead to obesity and unhealthy eating habits.
- **SERVE SMALL PORTIONS OF FOOD—LESS THAN YOU THINK YOUR CHILD WILL EAT.** If you serve your child a small amount on a large plate, he is more likely to finish it and gain a sense of accomplishment. If your child seems to want more, wait for him to ask for it. Avoid serving your child any foods that she strongly dislikes.
- **MAKE MEALTIMES PLEASANT.** Draw your children into mealtime conversation. Avoid making mealtimes a time for criticism or struggle over control. Do not talk about how much or how little your child eats.
- **DON'T EXTEND MEALTIME.** Don't make your child sit at the dinner table after the rest of the family is through eating.

How do I prevent feeding struggles?

The main way to prevent feeding struggles is to teach your child how to feed himself at as early an age as possible. By the time your child is 6 to 8 months old, start giving her finger foods. By 12 months of age, your child will begin to use a spoon and he should be able to feed himself completely by 15 months of age.

When you feed your child (before he is old enough to feed himself), you can wait for your infant to show you when he is ready to eat (by leaning forward, for example). Let him pace the feeding himself (for example, by turning his head). Do not put food into a child's mouth just because he has inadvertently opened it. Do not insist that your child empty the bottle, finish a jar of baby food or clean the plate.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child is losing weight.
- Your child has not gained any weight in 6 months.
- Your child also has symptoms of illness (for example, diarrhea or fever).
- Your child gags on or vomits some foods regularly.
- Someone is punishing your child for not eating.
- You have other questions or concerns.

Healthy Diet for Children

Eat three meals a day.

Breakfast is the most important meal of the day. Skipping breakfast actually makes a person eat more later in the day and often gain weight. Include fruits or vegetables in every meal, the fresher the better. Your child needs 16-24 ounces of milk a day.

Have family dinners.

Eat as many meals as possible together in the kitchen or dining room with the TV off. The more family dinners you have, the less likely your child is to develop obesity or behavior problems.

Limit junk food.

Offer healthy snacks. It's OK to have dessert occasionally, as a family. It's best not to buy chips, pop, candy and doughnuts. It's easier to limit your child's intake if those foods aren't available. Fruit juice does not add any nutrition, so it's best to limit that as well.

Increase the amount of fruits, vegetables and grains in the diet.

Follow these guidelines:

- Children should consume at least five servings of fruits and vegetables per day.
- Try to serve a fruit at every meal.
- Offer fruits as dessert and snacks.
- From a practical stand point, fruits and vegetables are interchangeable. Don't force children to eat vegetables they don't like. Offer ones they do like or substitute a fruit.
- Buy non-sugary cereals. Kids will like regular Cheerios®, Corn Flakes® and Raisin Bran® if that's what's offered. Lucky Charms® and Corn Pops® give your child far too much sugar and can lead to obesity.
- Use whole-grain bread in making sandwiches.

Make sure your child gets plenty of fiber.

Encourage your child to eat oatmeal, Cheerios, bran muffins, raisin bran, grapes, plums, prunes, prune juice, dried apricots, dried cranberries, raisins, dates, figs, popcorn, salads and whole-grain foods. Almost all breads, crackers, waffles, bagels, muffins and chips come in a whole-grain form, and those are the healthiest to buy. Cook with brown rice and whole grain pasta. Use whole grains such as barley and quinoa in soups.

Include an adequate amount of iron in the diet.

Throughout our lives we need adequate iron in our diets to prevent anemia. Iron is found in red meats, fish, poultry, iron-enriched cereals, beans of all types, peanut butter, dried fruits, sweet potatoes, leafy greens such as spinach and eggs.

*Written by B.D. Schmitt, M.D., author of "***Your Child's Health***," Bantam Books. Copyright 2004 McKesson Health Solutions.*
Source: U.S. Department of Agriculture and the U.S. Department of Health and Human Services
Provided by: The Education Department of the National Livestock and Meat Board

Picky Eaters

What is a picky eater?

The peak time for picky eating is the toddler or preschool years. A picky eater:

- Complains about or refuses specific foods, especially vegetables and meats
- Pushes foods around the plate
- Eats enough total foods and calories per day

What causes it?

Children of all ages (and adults) commonly have a few food dislikes. Sometimes children dislike foods because of their color, but more often it's because they are difficult to chew. Children accept tender meats better than tough ones, and well-cooked vegetables better than raw. Some children are repulsed by foods with a bitter taste.

How long does it last?

Most children who are picky eaters will try new foods in the school years because of peer pressure. The voracious appetite during the adolescent years also increases the willingness to experiment. Do not force your child to eat something he doesn't like.

How can I help my child?

- **TRY TO PREPARE A MAIN DISH THAT EVERYONE LIKES.** Try to avoid main dishes that your child strongly dislikes.
- **ALLOW OCCASIONAL SUBSTITUTES FOR THE MAIN DISH.** If your child refuses to eat the main dish, you may allow a substitute dish. An acceptable substitute would be breakfast cereal or a

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simple sandwich the child prepares for himself. Never become a short-order cook and prepare any extra foods for mealtime.

- **DON'T WORRY ABOUT VEGETABLES, JUST ENCOURAGE MORE FRUITS.** Vegetables can be entirely replaced by fruits without any nutritional harm to your child. This is not a health issue. Don't make your child feel guilty about avoiding some vegetables.
- **ASK YOUR CHILD TO TASTE NEW FOODS.** Many tastes are acquired. Your child may eventually learn that she likes a food she initially refuses. For some picky eaters, it may take seeing other people eat a certain food 10 times before they're even willing to taste it, and another 10 times of tasting it before they develop a liking for it. Don't try to rush this normal process of adapting to new foods.
- **DON'T ARGUE ABOUT DESSERT.** Do not have a rule that if you don't clean your plate, you can't have any dessert. Do not use dessert as a bargaining tool.
- **DON'T EXTEND MEALTIME.** Don't keep your child sitting at the dinner table after the rest of the family is done. This will only cause your child to develop unpleasant associations with mealtime.
- **KEEP MEALTIMES PLEASANT.** Make it an important family event. Draw your children into friendly conversation. Tell them what's happened to you today and ask about their day. Talk about fun subjects unrelated to food. Tell jokes.

When should I call my child's healthcare provider?

Call during office hours if:

- Your child is losing weight.
- Your child gags on or vomits certain foods.
- You have other questions or concerns.

Assistance for Families

If you have a life-threatening emergency, call 9-1-1.

Family Resources

The Everett Clinic Center for Behavioral Health	425-339-5453
Compass Health/Family Counseling Services	425-349-6200
King County Crisis Line	866-427-4747
National Alliance on Mental Illness Helpline	800-950-6264
Parents Place	206-542-3421
Volunteers of America Crisis Line	800-584-3578

Child Care And Nutritional Information

Volunteers of America for Referrals	425-259-3191
Edmonds Community College for Referrals	425-640-1247
Everett Community College for Referrals	425-388-9100
Providence Children's Center	425-258-7311
Dale Turner Family YMCA (Shoreline)	206-363-0446
Everett Family YMCA	425-258-9211
Marysville Family YMCA	360-653-9622
Mill Creek Family YMCA	425-337-0123
Mukilteo Family YMCA	425-493-9622
Northshore Family YMCA (Bothell)	425-485-9797
Stanwood-Camano Family YMCA	360-629-9622
Washington State Department of Early Learning	866-482-4325
Woman, Infants & Children (WIC)	800-841-1410

Pregnancy Resources and Options

Lutheran Counseling Network	425-258-2955
Planned Parenthood	425-339-3389
Pregnancy Aid	425-252-6444

Parenting Resources

Catholic Community Services	425-257-2111
Compass Health	425-349-6200
Department of Social and Health Services	800-737-0617
For the Kids Sake – Parenting Classes	206-694-5700
Parents Without Partners	206-517-2700
Parent Trust for Washington Children	206-233-0156

Volunteer Opportunities

Division of Children and Family Services, Everett	425-339-4768
United Way of King County	206-461-3700
United Way of Snohomish County	425-921-3400
Volunteers of America	425-259-3191

2-1-1

2-1-1 is the telephone number that connects you to health and human services in the community. There are hundreds of social services 2-1-1 can help you access, such as job training, food, shelter or support groups.

Please keep this book for future reference.

It contains important information which will assist you in caring for your child during illnesses and minor emergencies.

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