Information for Parents

from

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Important Note

Please talk to me before making any changes in your baby's diet.

Breastfeeding is the preferred method of feeding your newborn; however, there are other excellent infant feedings that are appropriate for you to use if breastfeeding is discontinued. Lately, there has been discussion about who should properly recommend infant formulas. I am concerned about this trend and hope if you have any questions about infant formula use and selection that you would contact my office.

The American Academy of Pediatrics has condemned the practice of promoting these products in the media. The Academy believes, as I do, that your pediatrician should be the one to make these important nutritional decisions. Nutrition of your baby is too important a subject not to discuss it with my staff.

You and I must remain in control of your baby's nutrition during the important first year of life.

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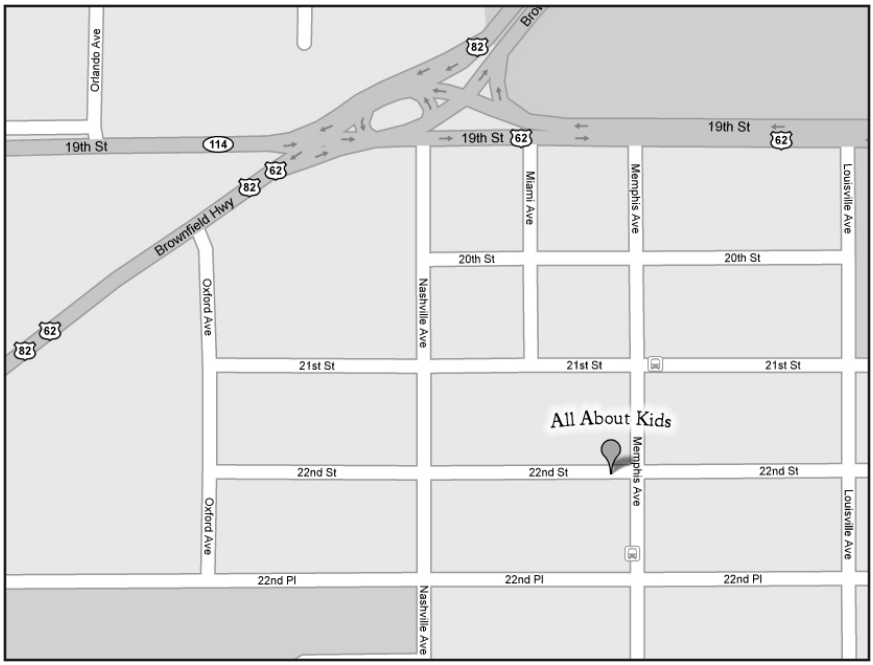
Map


All About Kids
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Orlando Ave
Brownfield Hwy
Oxford Ave
Oxford Ave
Nashville Ave
Nashville Ave
Miami Ave
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Important Telephone Numbers

Poison Control Center Phone _____

Emergency Squad Phone _____

Child's Doctor
Dr. Alami
3813 22nd St. Suite E
Phone: (806) 792-8922

Office Hours
Monday — Friday
8am — 5pm

Hospital _____

Address _____

Phone _____

Phone Numbers

Father's Work Phone _____

Mother's Work Phone _____

Neighbor Phone _____

Relative Phone _____

Child Care Center Phone _____

Baby-sitters Phone _____

Taxi Phone _____

Insurance Company

Policy Number _____

Phone _____

Office Instructions

After Hours Call

After hours or on weekends or during vacations, an answering service number will be provided for you to call. If you feel that your child's problem is an emergency, say so! The answering service will page us. Occasionally problems do occur with our communication systems. If we have not returned your call within 30 minutes, call back and request a second page. If the call is not an emergency, the answering service will take a message and we will call you back when we retrieve our messages, usually every 3 hours. Occasionally, the phone numbers are given to us incorrectly, phone are out of order, or the phone line is busy with conversation. Please keep your line free and call back to check if we have received your call and correct number.

Emergencies

If you have a life threatening emergency, go to the emergency room! If time allows, contact me first! I can direct you to the hospital that can best treat your child's particular illness.

Non-Emergency Calls

Routine calls concerning your child's health are best handled during regular office hours. Only myself or my nurses give medical advice. We will contact you at our earliest convenience.

Appointments

Appointments are required for all office visits.

All phone calls for appointments are handled in the order received. Please be patient and do not hang up to call again as this will further delay scheduling your appointment. Well visit appointments should be scheduled at least two weeks in advance. This assures you will obtain the appointment on the day, and at the time most convenient for you.

Sick visit appointments can usually be scheduled for the same day you call.

If your appointment has already been scheduled, and you wish to have another child seen, please call so that our schedule may be adapted to accommodate an additional patient. This courtesy will help us avoid unnecessary delays in seeing all patients.

In Pediatrics, emergencies are inevitable and may interfere with appointment schedules. Should such an emergency interfere with your appointment time, your understanding and cooperation will be greatly appreciated.

If you are unable to keep your appointment or if you will be late, please contact the office as soon as possible. This courtesy allows us to be of better service to other patients.

Payment for Services

Payment for office visits is expected at the time services are rendered unless prior arrangements have been made with the Business Manager. Payments may be made by cash, check. Visa, or MasterCard. *There will be a $10.00 charge for all returned checks or disallowed credit payments.

Insurance Filing

Our business office will file insurance claims for all hospitalizations. Please be sure we have current, complete insurance information. Payment for all services is ultimately your responsibility whether or not those services are covered by your insurance policy. If you have any insurance questions, please contact our office. Although we do not file insurance for office visits, we greatly simplify the process for you by providing the information needed at the time of your visit.

Health Record

We process forms for school and day care if we have seen your child for a physical exam within the last year. There is no charge for this service, so please include a self-addressed stamped envelope and complete the form as much as possible. Please allow 24-48 hours for completion of these forms. We will also provide a shot record when your child begins receiving immunizations at our office. Please keep this record in a safe place and bring it with you for your office visits. Whenever shot record information is needed for school or day care, have the record copied for them. Always retain the original for your files.

Confidentiality

Your medical record is strictly private. We will not release information without your written permission. The only exception is when the release of this information is required by law. We do not release information over the telephone since we have no way of knowing who is placing the call. This is done for your own protection. Your understanding and cooperation will be most helpful.

Telephone Calls

If you have questions regarding your child's growth and development or about specific non-emergency situations, you may call during routine business hours (8 a.m. - 5 p.m.). Sometimes it may be necessary for you to leave a message and a nurse will return your call as soon as possible, but be assured that all of your questions will be answered.

Message to Parents

Nothing holds more wonder, hope and opportunity for self growth than becoming a parent. It is also a time of puzzlement and many questions at a time when parents feel a deep need to know everything that will help their new infant flourish. This need embraces three major concerns:

1. Mastering the basic routines for the physical care of your baby.
2. Enjoying your relationship with your baby to the fullest.
3. Doing everything possible to help your baby develop to his or her fullest

potential.

Hopefully, this manual will help a little with these concerns. No two babies are alike in their growth, development and personalities. Therefore, the majority of information you will need will come from well childcare visits and phone conversations with our nursing staff and myself.

A baby/child visit gives us the opportunity to work toward our goals outlined in the previous paragraph. A health promotion visit generally includes the following:

1. Review events from the last visit to present.
2. Growth measurements and Development milestones.
3. Physical exam.
4. Anticipate developmental milestones until the next visit.
5. Finally, a discussion about your concerns and guidance concerning the future until your next visit.

Your Newborn Baby

Your new baby is evaluated in the hospital by us daily. We will discuss all about your baby with you over the next few days. We have attempted to pro some written details that should answer some of the most common questions

Fathers

We encourage fathers to take an active part in the care of your new baby. The more you participate in the life and care of your baby, the more important of a role you will have in the growth of your child.

Weight

Most babies will lose 5% to 10% of their birth weight during their hospital stay; This happens because the baby's body at birth contains an excess of fluid and this is nature's way of bringing the baby to a truer weight. Should there be any abnormal weight loss, we will inform you of it immediately.

Cord

The cord has been securely clamped and treated with an antiseptic to prevent infection. We will inspect it daily.

Eyes

Most babies' eyes are puffy and swollen during the first few days of life. Because of this, your baby may not open its eyes well. The swelling is sometimes caused by the medication which was used at the time of birth to prevent infection. The puffiness should disappear within several days.

Skin

The baby's skin may be peeling, red, irritated, or have minor rashes. This is an extra layer of skin that most babies shed during the early newborn period. Normally the feet and hands are often blue during the first few days of life.

Molding of the Head

The process of birth often causes the baby's head to be misshapen. This will correct itself without any specific treatment within a few days.

Breast Enlargement

Frequently, a newborn's breasts may enlarge sometime after birth and, occasionally, a little milk runs out. This is caused by the mother's hormones: this swelling will subside without special treatment.

Breathing Sounds

Your baby will normally breathe through his nose for the first few months. This breathing is often quite loud and the infant sounds as though he might have a cold. This is cause d by a loose nasal membrane. If your baby does have a cold, he will have nasal discharge; then we should be called.

Female Genital Area

It is important to separate labial folds when washing a baby girl. A little vaginal secretion and even bleeding sometimes occurs when the baby is a week or two old; this no cause for concern. This is a quickly passing effect of mother's hormones.

Birthmarks

Many types of birthmarks are seen in infants at birth or during the early months of life. As a parent, you are naturally concerned over the cause of these spots and their management.

The cause is usually unknown. They are certainly not related to your being scared by a fire engine, as the old wives tale would have you to believe. Nothing that you did or didn't do during your pregnancy produced the birthmark, so don't worry on that score. In general, the great majority of birthmarks fall into the following classes:

1. The flat type which occurs commonly at the nape of the neck, up in the hair line, and also splotchy across the face in the area of the bridge of the nose or the eyelids. These markings are simply enlarged blood vessels. Some days they show up more prominently than others. Treatment of these markings is rarely indicated. They gradually fade away, usually by the time the child is six months of age. Some may not completely disappear until the child is several years old.
2. The second type is the so called "strawberry birthmark." This type is raised and seems to have fluid in it. These as a general rule, grow sometimes rapidly until the child is about eight months old. Then they gradually begin to break up in the middle, become pale and fade.
3. There are other types of birthmarks which are less common. If your baby has one of these birthmarks such as port wine stain, we will discuss it with you.

The great majority of these will fade spontaneously and do not need to be removed surgically or by dry ice, or laser. In general, however, the treatment program we recommend is one of watchful waiting. Furthermore, there are less scar results when these spots are treated in this manner.

Bowel Movements

The stools of a newborn are normally yellow and pasty, or may even be green. This depends a great deal on the type of milk you are using. Bowel movements may be as frequent as once after each feeding or may occur only once a day. Diarrhea is not just two or three loose stools daily; a diarrhea stool is one that is mostly water and that "squirts out." Breast fed babies frequently have loose watery stools. Constipation, like thumbsucking, is often a source of unnecessary worry to the new mother. Daily stools are not necessary. If infrequent stools cause the baby discomfort, you may use an infant glycerin suppository once daily or offer one-half ounce of prune juice and one-half ounce water each day. It is expected for a baby to push, strain, draw his legs up, cry and become red in the face when he has a bowel movement.

Hiccups

Hiccups are common during the first few months. They are not caused by improper feeding and they do not cause the baby any discomfort.

Sneezing

Newboms normally sneeze. If there is no nasal drainage or "congested breathing", do not be concerned.

Feeding Your New Baby

Your first decision is whether to breast feed or bottle feed. This decision has probably been made prior to delivery. If there are questions concerning this decision feel free to callus. The feeding experience should bean enjoyable one for baby and mother and a time to share love. If problems arise please call us.

Hold your baby comfortably in your arms while feeding. His head should be elevated and he should feel secure. This is the time when you and your baby get to know each other. Find yourself a quiet place where you can sit and be comfortable with everything you will need in easy reach.

We believe in a semi-demand feeding schedule. A rigid schedule of every four hours may not suit your baby. We prefer our babies to be fed every 2.5 to 4.5 hours during the day. If he sleeps more than four and a half hours, you may awaken him. If he sleeps longer at night, count your blessings.

Burping

All babies swallow air during the feeding and should be burped once or twice during each feeding and again when the feeding is completed. To burp him, hold him upright over your shoulder and pat or rub his back very gently until he lets go of the air. If the burp doesn't come up early, it sometimes helps to put him on his back for a few seconds and then bring him up to your shoulder. Some babies do not burp well. If after five minutes your baby does not burp, he should be placed in the crib on his right side.

Vitamins and Fluoride

Most formulas contain extra vitamins, so a supplement is not required. When preparing the formula with fluoridated tap water, fluoride is automatically added. City water has fluoride, but many surrounding towns do not. If you are unsure we suggest that you check with your water treatment officials. If there is inadequate fluoride in your drinking water we suggest that your child receive fluoride supplements to prevent tooth decay.

For nursing infants to receive optimal nutrition, extra vitamins with fluoride (Tri-Vi-Flor) are recommended. We will give you a prescription for these at the two week check up.

Breast Feeding

If you plan to breast feed your infant, the following instructions may be of some help to you. You will not have much of a milk supply until the baby is three or four days old. Frequent, short feedings are better than infrequent lengthy feedings. Slowly increase the amount of time until you reach a maximum of fifteen minutes on each breast.

You should be in a comfortable position, either in a moderately low armchair or lying on your side. The baby should be in a semi-upright position so his head is higher than his stomach. With one arm, hold the baby so his face is close to the breast. With the other hand, hold the breast between your index and middle fingers so it is easy for the baby to reach the nipple without it covering his nose. Bend your arm to form a cradle so the baby's head is always supported making it easy for him to reach the breast. Touch the side of his face close to his mouth to the breast. He will turn his head and begin nursing.

Once your milk is well established be sure the first breast is completely emptied before changing sides (approximately fifteen minutes). For the next feeding, make sure you start with the breast that was not completely emptied the previous feeding. You are working on a supply and demand system. When the baby completely empties the breast, that is the message for the breast to produce more milk the next time. During some feedings, the baby may get slightly less than she would like to have. Your breast milk production will quickly increase to supply her needs. Keep nipples dry between feedings; do not allow milk to cake.

After the second week you may give the baby one bottle of formula or refrigerated breast milk each day if you so desire. Our office recommends Enfamil LIPIL with Iron. Give this bottle in the evening; let the father feed the baby. For the supplemental bottle, you may use a premixed formula such as Enfamil LIPIL with Iron. The powder is best for this since it will keep with refrigeration after it is opened.

For successful breast feeding, it is essential to have plenty of rest, drink lots of fluids, and eat a balanced diet. Any food, including chocolate may be eaten in moderation. Wash your breasts once or twice daily with soap and water and rinse well. You should continue your prenatal vitamins while you are breast feeding your baby. You may call our office with any and all of your breast feeding questions.

Bottle Feeding

Milk should flow freely from the bottle when the bottle is turned upside down. The milk should drip out as water would drip from a faucet. If the flow is too slow, enlarge the nipple holes by heating the end of a needle to a red hot heat over an open flame. While the needle is red hot, puncture two or three holes in the nipple.

For the first two days after a baby is born, he isn't interested in eating a lot. His appetite will gradually increase to where he will be taking from 2 to 4 oz. each feeding. The exact amount he will take depends on a lot of factors; how big he is, how often he eats, whether he is in a growth spurt, etc. Babies are very good at taking as much as they need as long as we offer them enough at each feeding is to allow for a little extra milk to be left in each bottle. When your baby is emptying the bottle each time, it is time to increase the amount of milk given.

There are a variety of Emfamil LIPIL with Iron forms; concentrate, powder, and Ready -To-Use. The concentrate is easy to use and the most popular. The powder is cheaper, yet slightly more difficult to prepare. Emfamil LIPIL with Iron Easy Ones are premeasured sticks of powder that make one 8 oz. bottle. Easy ones are great for travel. The Ready-To-Use is the most expensive and contains no fluoride.

Ordinarily, the baby gets enough fluid in his formula. However, during hot weather, he may need extra fluid. You may offer one or two ounces of tap water several times a day between or after feedings. Boil the water if it comes from a well. If he doesn't seem to want it, don't force it. Your baby's own desires are usually the best guide as to the amount he needs.

Washing the bottle in hot soapy water or in the dishwasher is adequate and perfectly safe. Sterilizing the formula after it is mixed is necessary only if using water from an untreated source, e.g.: well water, or if the bottle will be kept unrefrigerated more than a few hours.

Taking Your New Baby Home

Your baby has made the first and most important adjustment of his or her life. You are now taking your new baby home. We hope the following suggestions will help make your adjustment together at home easier.

Visitors

We realize you are eager to show off your new baby. However, many people carry infections even though they feel well and these can be transmitted to your baby. We recommend that you screen visitors for at least the first month. (If they are unhappy with you, tell them it's doctor's orders.)

Clothing and Bed Covering

The baby's clothing should be light, loose and simple. Most babies are overdressed; they need fewer clothes than adults. The room temperature should be maintained at 68 to 78 degrees. The room should not be too dry, and should be well ventilated with an even temperature day and night. Keep the baby dressed in diaper, shirt and gown except in hot weather when the gown may not be needed. Use a lightweight cotton blanket at night. The bassinet pad should be firm, not soft, and you should not use any pillows. The bassinet or crib mattress should fit snugly against the sides, a bumper pad may be used to protect the child from the side rail.

Fresh Air and Sunshine

If your baby is gaining weight and is doing well at one week of age, he may be taken outdoors, weather permitting. He may be given a sun bath for about five minutes each day, gradually increasing the time interval to avoid sunburns.

Diapers and Diaper Rash

You may use disposable or cloth diapers. Disposable diapers are convenient but usually more expensive to use. Diaper liners may be used with cloth diapers. Rinse soiled diapers in the toilet bowl immediately after changing the baby, then put them in a covered pail with Boraxa or Borateema in the water. Wash baby's diapers and clothing in Ivory or Dreft, the mild baby soaps. We do not recommend the use of bleach or fabric softeners since these often cause a rash. You may use one cup of vinegar in the last rinse to act as a softener. Diapers done at home are the most economical

The best prescription for diaper rash is prevention. We recommend prompt diaper changes, thorough cleansing, and thorough drying of the diaper area.

The Bath

A newborn only needs to be bathed 2 to 3 times a week during the first year. It is usually most convenient to give the bath before the mid-morning feeding. Until the navel and circumcision are healed, a sponge bath should be given using water and a mild soap. Afterward, the bath may be given in a pan, bathinette or kitchen sink. The water should be lukewarm (about body temperature). Hold your baby so his head is supported on your wrist; wash his face first using a soft wash cloth without soap. Never leave your baby unattended in the bath. After the bath, baby lotion may be used on the body. We believe that oil causes many rashes if used on the body and we do not recommend it. The scalp needs washing only once or twice a week. You may use bath soap or baby shampoo. Do not oil the scalp. Wash the baby's ears; do not poke into the canal. The dried mucus or crusts which may form just inside the nose may be wipe off gently with the corner of the wash cloth; do not push a cotton swab up the nose.

Circumcision

Tub baths should not be given until your son's circumcision heals. Vaseline should be placed on the raw edges with each diaper change for the first week after your son comes home from the hospital.

If a plastic rim has been used, it usually drops off in five to eight days following circumcision. No special dressing is required and the baby can be bathed just as though he has not be circumcised. Notify us if the healing does not proceed as described, if you should observe any unusual swelling, or if the plastic ring is not off within ten to twelve days. After the healing is completed, it is important to continue pulling the foreskin back from the ridge. This will prevent the formation of attachments between the foreskin and head of the penis.

Sleeping

We probably get as many questions regarding sleeping and sleep disorders as we do about anything. Sleep, or the lack of it, effects the baby, mother, father, siblings, pets, and anyone else within earshot. Babies have a wide range of sleep needs, 12 to 20 hours a day. Initially their sleep is broken into fairly equal segments distributed over the whole 24 hour period. Only half of all babies sleep for 6 hours straight at 6 weeks of age. Do not expect that your baby will sleep from 8 PM to 8 AM when he is 2 weeks old. If your baby was active at midnight before delivery, he will probably be active at midnight after delivery. He has no way of knowing that you have a pattern of being awake when the sun is up and asleep when the sun is down.

Patterns and habits take time to change. Feeding cereal at night or trying to tire her out before bedtime have little or no effect on changing patterns. The easiest course is for

you to work with the baby's sleep pattern initially. You take naps during the day when the baby is asleep. Strive for a good feeding at 10 to 11 PM. When the baby awakens for the 2 AM feeding, make this a business session. Turn on just enough light to find him, feed him, change his diaper if needed, and put him back to bed. Save your social interactions for the daylight hours. This is the way that you inform your baby of the sleep pattern that you would prefer. It is a good idea to put the baby to bed when they are awake so they can learn how to fall asleep. There is nothing wrong with rocking your baby. It is rocking your baby to sleep that sets up a pattern that may lead to difficulties down the road. If these suggestions are not working or if you are becoming frustrated let us know. We may need to evaluate the baby to see if there is a problem which is preventing this transition.

We recommend that normal infants be positioned on their side or back when they are put down to sleep. This does not mean that the baby must be kept in that position. You don't have to stand at the bedside and move them back if they roll over. The risk of Sudden Infant Death Syndrome for an infant placed in the prone position (laying on the stomach) is extremely low. Recent studies suggest that placing a normal infant on the side or back may make that risk even lower. In special circumstances, such as certain premature infants or babies with swallowing disorders, the prone position may be the position of choice.

Immunizations

Your baby needs to get a number of vaccinations within the first year that protect against 10 major childhood disease. The baby should receive most of the immunizations before his or her second birthday.

Accidents

Automobile accidents are the major cause of death in children one to fourteen years old. Accidents claim more lives in this age group than do the six leading pediatric disorders. For every child that dies, approximately forty are injured and many of these remain permanently physically and/or mentally disabled.

Proper restraining devices could save the lives of 90% of accidents involving children under five years of age and in 80% of accidents involving older children. These restraining devices could also reduce serious injuries by 70% in these two age groups. As caring pediatricians, we believe it is most important to advise parents that automobile safety is a must. IMMUNIZE YOUR CHILDREN against the leading cause of childhood death.

We recommend that you read the most recent "Consumer Reports" concerning children's car seats. We will be happy to discuss this with you.

START WITH YOUR CHILD'S FIRST AUTOMOBILE RIDE,

THE ONE HOME FROM THE HOSPITAL.

DON'T RISK YOUR CHILD'S LIFE.

When To See A Doctor:

- Excessive crying. It's normal for your baby to cry when he or she is hungry, needs to be burped, is cold, or needs a clean diaper; however, if the baby's cries sound peculiar or last for an unusual length of time, it could be a medical problem.
- Abnormal sleep. A newborn will spend most of the time sleeping. However, if the baby is rarely alert, does not wake up for feedings, or seems too tired or uninterested to eat, see us right away.
- Infection of the umbilical cord. If you notice that the stump becomes infected (pus or red skin at the base of the cord, or crying when you touch the cord or skin next to it), alert us.

Things To Do:

- Give your baby lots of love and attention. You can't "spoil" a baby at this age.
- Whenever you travel in a car, place your baby in a safety seat that is installed correctly in the back seat facing the back.
- Create a safe environment for your newborn by child-proofing your home.
- Take your baby for all the recommended checkups and vaccinations.
- Don't allow smoking or smoke around your baby.

A Nursing Mother's Guide to Successful Breastfeeding

In the first months of life, breastfeeding can supply all your baby's nutritional needs and be a deeply satisfying experience for you both. The more your baby nurses, the more milk you will produce, automatically adjusting the supply to meet your baby's needs. This Q and A will answer question most new parents have about breastfeeding, teach you nursing techniques that will make breastfeeding go smoothly, and help you solve nursing problems if they arise.

Q: What's the best position for nursing?

A: There are three common positions. Changing the position from one feeding to another wards off potential problems by ensuring that milk is drained from all areas of the breast.

- In the traditional cradle position, mother sits in a comfortable chair, holding the baby in one arm with his head in the crook of her elbow. She uses her other hand to lift her breast, compress the nipple and areola with her second and third fingers (or thumb and first finger), and guide nipple and areola into the baby's mouth.
- In the football hold (so-called because the baby is tucked under the mother's arm the same way a football player holds a football), mother sits on a sofa or bed with baby lying on a pillow at her side. Mother holds the baby's head with one hand, using the other to hold the breast and guide nipple and areola into the baby's mouth.

- In the lying down position, mother and baby lie face to face in bed. Mother has one arm under her head, and uses her free hand to life her breast and place nipple and areola in the baby's mouth.

Q: What happens next?

A: Baby "latches on" to the breast, with the nipple and most of the areola in his mouth with his lips flanged out around it. You'll feel a firm (but not painful) pull as baby's sucking pulls the nipple into an elongated shape and presses it against the palate. If baby isn't firmly latched on, he won't be able to nurse. If you don't feel the firm pull, take baby off the breast, move him into a position that feels more comfortable, make sure he has the areola in his mouth, and try again. The football position works particularly well for babies who have difficulty latching on. Inverted nipples that lie flat against the breast and don't elongate when stimulated make latching-on difficult. Wearing plastic breast shells (also known as Swedish milk cups) inside your bra for several hours a day during the last month of pregnancy and the first few days of nursing will help pull the nipple out and improve latch-on.

Q: How do I know milk is flowing?

A: As the baby begins to suck, milk is "let down" from the ducts where it is stored and starts to flow from the nipple. Signs that "let-down" has begun include:

- milk dripping from the opposite breast;
- loud gulping noises, as baby swallows the milk that squirts into his mouth;
- in the first days after birth, what feel like brief menstrual cramps, as the uterus contracts in response to the oxytocin hormone that makes the milk flow. These cramps help your uterus return to its prepregnant state and cut down on postpartum bleeding;
- After the first weeks, a tingling, "pins and needles" feeling in both breasts as the baby starts to nurse.
- When nursing is well established, flow of milk from the breasts when it's time for a feeding or when you hear your baby (or even someone else's baby) cry. If it's not the right time or place, you can stop let-down by pushing both fists hard against the center of the breast and nipples and holding that position until the pins and needles sensation of let down stops.

Q: How can I tell if the milk is getting to the baby?

A: To get the milk, baby needs to establish an effective rhythm of sucking and swallowing. You should be able to hear the swallowing and see the muscles in front of baby's ear moving rhythmically as he sucks. If baby doesn't sustain rhythmic sucking and swallowing, sucks softly and fleetingly, takes long rests, swallows only occasionally, or falls asleep after only a few minutes at the breast, he's not taking in milk. Don't let your baby make this nonnutritive or "pacifier" sucking a habit, or he may not gain weight the way he should. Take him off the breast and wake him up by handling or undressing him. When you reposition him at the breast, make sure he has latched on properly, and keep him awake and stimulated by stroking him or gently scratching his back. Limit the total feeding time to 30 minutes, to encourage the baby to stay awake and active during nursing.

Q: How do I know my baby is getting enough to eat?

A: Things are going well if your baby is eager to nurse, sucks rhythmically at both breast for 10 to 25 minutes, and seem content after nursing. He should have at least six wet diapers a day, pass several liquid, mustard-colored stools a day, and wake up to feed at lest every four hours, at night as well as during the day. Ideally, babies should be nursed every two to three hours. If you don't nurse often enough, your milk supply will diminish and your baby may not get enough calories for proper growth.

Q: What can I do to feel well and nurse well?

A: Get as much rest as you can. A fully breastfed infant should be fed 8 to 12 times a day, so you will need help with childcare and house keeping chores. Because the let-down reflex is inhibited by distractions or anxiety and enhanced by relaxation and togetherness with the baby, arrange to nurse in a comfortable, peaceful atmosphere. Put your feet up, close your eyes, drift off to sleep if you like.

Nursing mothers should eat well (about 500 to 1,000 more calories a day than before you were pregnant, but somewhat less than you ate during pregnancy), drink plenty of fluids and limit caffeine intake to one cup of coffee or other caffeinated drink a day. Eat the foods you enjoy (babies are not harmed by garlic, chocolate, onions, or other tangy foods), drink milk only if you like it, and don't diet. Your extra pregnancy weight will drop off gradually over the course of several months to a year. You won't menstruate (or, probably, ovulate) until four to nine months after delivery, but don't rely on nursing for family planning. If you don't want to get pregnant, use contraception.

Q: Will nursing hurt my breasts?

A: No, but you may have to cope with a few problems in the first week or so. Some women, especially fair-skinned blondes and redheads, have sore or cracked nipples that are painful, especially at the start of nursing before let-down occurs.

You can relieve soreness by drying your nipples after each feeding with a flow of warm air from a hairdryer at a low setting, or by holding a lamp with a 60-watt bulb 8 to 12 inches from the nipples for about 15 minutes. If you have a crack or cut on one nipple, put the baby on the intact breast to initiate let-down, then switch him to the cracked nipple. Don't nurse more than eight minutes on that side, then switch to the intact breast.

Taking acetaminophen 15 minutes before nursing can help. Make sure that clothing that touches your nipples is soft. Don't use nipple shields (they interfere with nipple stimulation and cut down your milk supply) or breast pads (they keep the nipple from drying), and don't wean the baby. The problem is temporary.

Mastitis, and inflammation of the breast, can occur at any time during the breastfeeding period. The symptoms are a tender, red, dimpled quadrant of the breast, a feeling of having the flu, and often a fever. Mastitis may follow a clogged duct or area of the breast that hasn't been properly drained with nursing. If you develop these symptoms, callus or your obstetrician. The usual treatment is antibiotics, more frequent nursing, rest, and warm packs to the breast while nursing. Neither the mastitis nor the antibiotic will harm the baby, but if an antibiotic is prescribed for you, please inform us. Do not stop nursing. Abrupt cessation of nursing will cause milk to accumulate in the breast and may lead to an abscess.

Call our office if:

- The baby fights the breast, can't stay latched onto the nipple, or cries after nursing for a minute or two.
- The baby falls asleep early during a feeding and cannot be kept awake long enough to feed adequately.
- The baby sleeps longer than four to five hours at night in the first two to three weeks, without awakening to feed.
- The baby has fewer than six wet diapers a day, or has diapers that are only damp.
- The baby passes little stool, or has dark green, mucous stools.
- The baby's color is pale, blue, or yellow with jaundice.
- The baby has rectal temperature higher than 100.5 degrees.
- The baby is very fretful and cannot be contented by nursing.
- The baby seems weak and apathetic.
- You are taking any medication, prescribed or over-the-counter, while nursing.
- You have any questions or concerns about nursing.

Guidelines for breastfeeding:

Milk Supply:

- First 24 hours: You maybe able to express a few drops of milk.
- Days 2-3: Milk should come in between the 2nd and 4th days
- Day 5: Milk should be in. Breasts may be firm or leak milk
- Day 6: Breasts should feel softer after nursing.

Baby's activity:

- First 8 hours: Baby is usually wide awake in first hours of life.
- Put to breast within 1/2 hour of birth
- 8-24 hours: Wake your baby. Babies may not awaken on their own to feed
- Day 2: Baby should be more cooperative and less sleepy
- Day 3-5: Look for early feeding cues: rooting, lip smacking, hands to face. Note that baby swallows regularly while nursing.
- Day 6 on: Baby should appear satisfied after feedings

Feeding Routine:

- First 8 hours - Baby may go into a deep sleep 2-4 hour after birth
- 8-24 hours - Feed your baby every 1 ‘/2 -3 hours as often as wanted
- Day 2-5 - Feedings should be at least 8 to 10 times each day
- Day 5 on - May go 1 longer interval, up to 5 hours, between feedings (in a 24 hour period)

Breastfeeding:

- First 8 hours: Baby will wake up and be alert and responsive for several more hours after the initial deep sleep
- 8-24 hours: Nurse at both breasts as long as baby is actively sucking and mother is comfortable
- Day 2: Try to nurse on both sides at each feeding, aiming for 10-15 min each side. Expect some nipple tenderness
- Day 3: Consider hand-expressing or pumping a few drops of milk to soften the nipple if the breast is too firm for the baby to latch on
- Day 4-5: Nurse at least 10-15 minutes each side, every 2-3 hours, for the first few months of life
- Day 6 on: Mother’s nipple tenderness is improved or gone

Baby’s urine output:

- 8-24 hours: Baby must have at least 1 wet diaper in first 24 hours
- Day 2: Baby should have at least I wet diaper every 8 hours
- Day 3: Wet diapers should increase to 4-6 in 24 hours
- Day 4: Baby’s urine should be light yellow
- Day 5 on: Baby should have 6-8 wet diapers per day of color less or light yellow urine

Baby’s stools:

- 8-24 hours: Baby should have a black-green stool (meconium stool)
- Day 2: Baby may have a second very dark (meconium) stool
- Day 3-4: Baby’s stools should be changing from black-green to yellow
- Day 5: Baby should have 3-4 yellow, seedy stools per day
- Day 6 on: The number of stools may slowly decrease after 4-6 weeks

Parents' Guide to Effective Feeding

1. Almost all children, at one time or another, don't eat as well as parents would like. If you are concerned about your child's eating, these guidelines can help:
2. Children do well with schedules. Try to keep mealtimes and snack times about the same each day.
3. Children need to eat often, not constantly. Offer something every two or three hours, to allow three meals and two to three snacks a day.
4. Make sure your child can reach food easily. Use a high chair, phone books, or small table.
5. Allow your child to feed himself or herself. Try very small amounts at first. Offer seconds later. Expect messiness, and be prepared for easy cleanup (bibs, newspaper under the high chair, or whatever works for you). If you're worried about how little food gets into the child's mouth, use two spoons: one for the baby to control, and one for you to feed.
6. No force feeding, bribing, or cajoling! This will backfire.
7. Don't worry if your child wants to eat the same food every day. Many children are like that. Variety is not important to a toddler's nutrition. What matters are total calories and protein.
8. At mealtimes, offer solids first. Liquids are filling and provide fewer calories
9. Limit the amount of juice, water and carbonated drinks. Offer milk or formula instead.
10. Offer foods that are easy for your child to handle: "finger foods" such as Cheerios, french fries, slices of banana, and peas. Make sure pieces are small to avoid choking.
11. For more calories per bite, add margarine, mayonnaise, gravies, and grated cheese to foods. For snacks, use peanut butter, cheese, pudding banana or dried fruit.
12. Limit "junk foods" such as soda, donuts, and candy. They have little protein and fewer calories than some other foods, and take up valuable space in the stomach without helping growth.
13. Eat with your child or allow your child to eat with others, so meals and snacks can be fun.

If these measures don't ease the problem and you are still concerned, call our office for an appointment. Bring a diary of what (and how) your child has eaten in the last week. If our measurements show that your child isn't growing at the same rate as other children the same age, we may tell you to add extra calories at meals. These simple recipes will help:

1. Super fruit

- 1 jar (4 oz.) strained fruit
- 1 scoop formula powder

2. Super milk (28 calories per ounce)

- 1 cup dry milk powder 4 cups whole milk

3. Super pudding

- 2 cups whole milk
- ½ cup dry milk powder
- 1 package instant pudding mix. Mix whole and dry milk together, then follow package directions. Makes four servings (116 calories/serving)

4. Super shake

- 1 cup whole milk
- 1 package Carnation Instant Breakfast
- 1 cup ice cream. Mix together in blender and pour (430 calories)

Note: Do not use recipes 2, 3, and 4 if your child does not tolerate milk protein or milk sugar (lactose).

Trained Night Feeder

The Solution

Gradually lengthen the intervals between daytime feedings to four hours or more. Nighttime feeding intervals cannot be extended if the daytime intervals are short. Gradually postpone daytime feeding times until they are more normal for your child's age. If you currently feed your baby every hour, go to 1-1/2 hours. If he cries, provide cuddling and a pacifier. It is important to provide your baby with periods of holding and cuddling separate from feeding times. For every time you feed your baby, there should be four or five times that you snuggle him without feeding. When your baby accepts a 2-hour schedule, go to two hours. For formula-fed babies, the feeding goal is four meals each day by 4 months of age. Breastfed babies often need five feedings each day until 6 months of age, when solid baby foods are introduced.

At naptime and bedtime, place your baby in the crib drowsy but awake. When your baby starts to get drowsy, place her in the crib. If she is very fussy, rock her until she settles down or is almost asleep, but stop before she's fully asleep. If she falls asleep at the breast or bottle, it is best to awaken her. To help dissociate feeding from the bedtime ritual, consider feeding her one hour before bedtime or naptime. Her last waking memory needs to be of the crib and mattress, not the breast or bottle. She needs to learn to put herself to sleep. She will need this self-quieting skill to cope with normal awakenings at night.

When your baby cries at naptime or bedtime, make brief contact every five to 15 minutes. Visit your baby before he become very upset and difficult to console. Younger or more sensitive infants may need to be checked on every five minutes. Gradually stretch out the interval between visits. Make these visits supportive, but brief and boring. 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 him,

rock him, play with him, or bring him to your bed. This brief contact will not reward your baby sufficiently to encourage him to repeat the behavior.

When your baby cries in the middle of the night rock her to sleep temporarily. Until your child learns how to put herself to sleep at naps and bedtime, make middle-of-the night awakenings as easy as possible for everyone. If she doesn't fuss for more than five or ten minutes, respond as at bedtime. If she cries longer, take her out of the crib and rock her to sleep. Don't turn on the lights or take her out of the room, however. Try not to talk much to her.

Feed your baby only once during the night. After the last feeding of the day - usually between 8 and 10 p.m., depending on your baby's age - feed him only once during the night and only after four or more hours have passed since the last feeding. Make this nighttime feeding brief and boring. If it takes more than 20 minutes, you are holding or burping the baby too much.

Eventually, phase out the last nighttime feeding. Do this only after the intervals between daytime feedings are longer than three hours AND your child can put herself to sleep without feeding or rocking. Gradually reduce the amount you feed your baby at night. For bottle-fed babies, decrease the amount of formula you give by one ounce every two to three nights. For breastfed babies, nurse on just one side and for two minutes less every two to three nights. After one to two weeks, your infant will no longer crave food at night. You can also expect your child to return to sleep without holding or rocking after nighttime awakenings.

Help your child attach to a security object. A security object, such as a cuddly stuffed animal, soft toy, doll, or blanket, can provide a source of reassurance and help your child separate from you. Sometimes covering a stuffed animal with one of the mother's T-shirts helps the child accept it. Include the security object whenever you cuddle or rock your child during the day. Also include it in the bedtime ritual by weaving it into your storytelling and tucking it into the crib next to your child. Eventually, she will hold and stroke the security object at bedtime in place of you.

Do not keep the crib in your bedroom, if possible. If the crib is in your bedroom, move it to a separate room. If this is impossible, cover one of the side rails with a blanket so your baby can't see you when he awakens.

Eliminate long daytime naps. After your baby has napped for two hours during the day, awaken her. If she is in the habit of taking three naps during the day, try to change her habit to two naps a day by delaying the first nap.

Don't change wet diapers during the night. Change the diaper only if it is soiled or you are treating a bad diaper rash. I f you must change your child, us as little light as possible (a flashlight, for example), do it quietly, and don't provide any entertainment.

If your child won't lie down in the crib, leave her in the standing position. Try to get her 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 her to lie down soon becomes a game

Keep a sleep diary. Use the attached sheet to record the time your child awakens in the morning, when and how long he naps during the day, and what you did to put him to sleep. At bedtime, record the time he went to sleep, how long it took, and what you did. For each time your child awakens at night, record the time, how long he was awake and what you did. Bring the diary to the next visit.

Call our office during regular hours if

- You're concerned that your child is not gaining adequate weight.
- Your child acts sick.
- You think the crying has a physical cause.
- Your child acts fearful.
- Someone in your family cannot tolerate the crying.
- The steps outlined here do not improve your child's sleeping habits within two weeks.
- You have other questions or concerns.

Adapted from Schmitt BD; Your Child's Health, ed 2. New York. Bantam Books, Inc.. 1991. This parent information aid on the trained night feeder may be photocopied and distributed to parents without permission of the publisher.

Trained Night Crier

Parental belief that any crying is harmful. All young children cry in response to change ("protest crying"). Crying is their only option before they learn to talk. Crying for brief periods is not physically or psychologically harmful. The thousands of hours of attention and affection you have provided for your child will easily offset any unhappiness associated with unlearning a bad sleep pattern.

If you follow the recommendations outlined below, your child's sleep habits will usually start to improve in two weeks. The older the child, the harder it is to change his habits. Infants over 1 year of age will vigorously protest any change and fight sleep even when they're tired. They may cry for hours. Without treatment, however, these children won't start sleeping through the night until 3 or 4 years of age, when busy daytime schedules finally exhaust them. By that time, you'll be exhausted too.

The Solution

At naptime and bedtime, place your baby in the crib drowsy but awake. It's good to hold babies and provide pleasant bedtime rituals. But when your baby starts to act drowsy, place her in the crib. Her last waking memory needs to be of the crib and mattress, not you. If she is very fussy, rock her until she settles down or is almost asleep, but stop before she's fully asleep. She needs to learn to put herself to sleep. She will need this self-quieting time to cope with normal awakenings during the night.

Help your child attach to a security object. A security (transitional) object is something like a cuddly stuffed animal, soft toy, doll, or blanket, can provide a source of reassurance and help your child separate from you. Sometimes covering a stuffed animal with one of the mother's T-shirts helps the child accept it. Include the security object whenever you cuddle or rock your child during the day. Also include it in the bedtime ritual by weaving it into your storytelling and tucking it into the crib next to your child. Eventually, she will hold and stroke the security object at bedtime in place of you.

When your baby cries at naptime or bedtime, make brief contact every 5 to 15 minutes. Visit your baby before she becomes very upset and difficult to console. Younger or more sensitive infants may need to be checked on every five minutes. You be the judge. Gradually stretch out the interval between visits. Infants cannot learn to comfort themselves without some crying. This type of crying is not harmful.

Make the visits supportive, but brief and boring. Don't stay in the room longer than one minute. Don't turn on the lights. Act sleepy. Whisper, "Shhh, everyone's sleeping." Add something positive, such as "You're a wonderful baby," or "You're almost asleep." Never show anger or punish your baby during these visits. If you hug him, he probably won't let go. So touch him gently and redirect him to his security object. This brief contact will not reward your baby enough to encourage him to repeat the behavior.

Do not remove your child from the crib. Do not rock her, play with her, or bring her to your bed. Most young infants will cry from 30 to 90 minutes and then fall asleep.

When your baby cries in the middle of the night, rock him to sleep temporarily. Until your child learns how to put himself to sleep at naps and bedtime, make middle-of-the-night awakenings as easy as possible for everyone. If he doesn't fuss for more than five to ten minutes, respond as you would at naptime and bedtime. If he cries longer, take him out of the crib and rock him to sleep. Don't turn on the lights or take him out of the room, however. Try not to talk to him. Help him learn to put himself to sleep at naps and bedtime, when everyone can better tolerate crying.

Do not keep the crib in your bedroom, if possible. If the crib is in your bedroom, move it to a separate room. If this is impossible, cover one of the side rails with a blanket so your baby can't see you when he awakens.

Eliminate long daytime naps. After your baby has napped for two hours during the day, awaken her. If she is in the habit of taking three naps during the day, try to change her habit to two naps a day by delaying the first nap.

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, us as little light as possible (a flashlight, for example), do it quietly, and don't provide any entertainment.

If your child won't lie down in the crib, leave her in the standing position. Try to get her 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 her to lie down soon becomes a game.

Keep a sleep diary. Use the attached sheet to record the time your child awakens in the morning, when and how long he naps during the day, and what you did to put him to sleep. At bedtime, record the time he went to sleep, how long it took, and what you did. For each time your child awakens at night, record the time, how long he was awake and what you did. Bring the diary to the next visit.

Call our office during regular hours if:

- You're concerned that your child is not gaining adequate weight.
- Your child acts sick.
- You think the crying has a physical cause.
- Your child acts fearful.
- Someone in your family cannot tolerate the crying.

- The steps outlined here do not improve your child's sleeping habits within two weeks.
- You have other questions or concerns.

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Colic and Crying in Young Infants

Colic or cramping stomach ache is present to a greater or lesser degree in most babies during the first three months of life.

If it is mild and occasional and only lasts for a few minutes in the evening, no one becomes very concerned. If, on the other hand, it occurs every day or every evening and lasts for several hours at a time, it upsets the baby, the mother and the whole household (and rightly so).

The cause or causes of colic are not completely and thoroughly understood in spite of much medical study. In general when y our baby cries out and draws his legs up with colic, it is because the muscle in his intestine is squeezing down on bubbles of air or gas. This cause him to cry out in pain. The pain is thought to be the type of pain that adults have who have intestinal cramps associated with loose bowels. Sometimes a few simple measures may be necessary before your baby obtains significant relief. Among the most common factors causing your baby to have colic or to cry excessively are the following:

1. Hunger.
2. Improper feeding technique leading to air swallowing. These include;
    a. Taking milk to fast or too slow.
    b. Taking overheated milk.
    c. Taking milk while lying down.
3. Immaturity of the baby's digestive system.
4. Nervous tension in the family and in the baby.
5. Intolerance to the type of carbohydrate or sugar in the formula.
6. Cow's milk allergy.

Treatment:

1. Make sure your baby is getting enough to eat. The formulas may need to be changed. More milk may need to be put in his bottle.
2. Prop him up during and after feeding. Interrupt him and "burp" him after each ounce he takes. Enlarge the nipple holes or get new nipples. It should take him 15-25 minutes to take his feeding. Don't overheat his formula. It should be given at body temperature. Don't screw bottle caps too tightly.

3. We will be glad to order a colic medicine if your infant is fussy. Give it as directed. It helps relax the baby's stomach and intestinal muscles as well as the baby. It is NOT a dope and is not habit forming.

4. Use a pacifier, try the rocking chair or walking him. Try putting him on his stomach. Don't worry about spoiling him the first three months. Comforting him makes him feel better and usually does the same for you. Get grandmother or a friend, neighbor or trust baby-sitter in to "take over" some evening and have your husband take you out to dinner and a movie.

Fever and Acute Illness

Here are some suggestions for you when your child becomes ill. These are general safe instructions regardless of his illness.

What is fever?

Fever is temperature elevation. It is a symptom and not a disease. Fever is a temperature over 101 degrees either orally, rectally, or under the arm.

Does high fever (104-105) mean severe illness?

No, not necessarily - Mild viral illnesses may cause high fever and severe bacterial illnesses may only have fevers of 102 to 103 degrees. Fever is usually higher at night.

Babies may have no fever and still be ill, just as they may run a high temperature with relatively minor cause. How your baby looks and acts is more important than temperature alone.

Does high fever cause brain damage?

Fever by itself does not cause brain damage or other types of permanent change. Does high fever cause convulsions?

Not necessarily. Approximately 5 children out of 100 will have a fever convulsion sometime during the first 5 years of life. Fever convulsions rarely occur after 5 years of age. These convulsions most commonly occur with rapid rise in fever rather than prolonged high fever. They rarely last more than 3 to 4 minutes and cause no brain damage. We should always promptly be notified if this occurs. Until you speak to us, place child on his side and bring his temperature down rapidly by placing a towel that has been soaked in cool water over his entire body.

Taking the Temperature

It is important to take your baby's temperature if you suspect he is ill. The temperature maybe taken under the armor rectally. In the older child, you may take it in the mouth. If you use a mercury type thermometer, always "shake down" the thermometer until the silver line inside is below the 96° F or 35.6° C mark.

1. Taking a rectal temperature. Use only rectal thermometers. Lubricate silver end with Vaseline and gently insert no more than one inch into rectum. Hold in place one minute.

2. Taking an Axillary or Armpit temperature. Place silver end of thermometer under bare, dry armpit. Hold the arm tightly against body. Hold thermometer in place for five minutes.

3. Taking and Oral or by mouth temperature. Gently place silver end of thermometer under the tongue. Close the lips around the thermometer. Caution child to not talk or bite thermometer while in place. Hold in place for three minutes.

Treatment of Fever

Low grade fevers (101 degrees or less) do not need to be treated at all. They generally do not make the child uncomfortable and may actually be beneficial during an illness.

Temperature of over 102 usually makes the child uncomfortable (aching, chilling, etc.) and for that reason you will probably want to give your child something for it. You do not need to awaken a sleeping child who is resting comfortably just to give him something for the fever. For fever due to illnesses, we recommend giving acetaminophen every 4 hours. The dosage of acetaminophen is:

Tempra®

Age	Weight	Drops	Syrup	80mg Tabs	160mg Tabs
under 4 mo	under 12 lb	1/2 dropper	1/4 tsp	X	X
4 to 11 mo	12-17 lb	1 dropper	1/2 tsp	X	X
12 to 23 mo	18-23 lb	1 - 1/2 dropper	1/4 tsp	X	X
2 to 3 years	24-35 lb	2 droppers	1 tsp	2	1
4 to 5 years	36-47 lb	3 droppers	1-1/2 tsp	3	1-1/2
6 to 8 years	48-59 lb	*	2 tsp	4	2
9 to 10 years	60-71 lb	*	2-1/2 tsp	5	2-1/2
11 years	72-95 lb	*	3 tsp	6	3
12 years & Older	96 lb +	*	4 tsp	8	4

Diet

You may always give fluids like water, tea, Kool Aid, and carbonated soft drinks. A child usually loses his appetite during illnesses, don't worry. Concentrate your efforts on encouraging fluid intake. As the infant or child improves, increase his diet by adding soft foods and then as he gets well, regular diet.

Activity

A child should be allowed activity within the house while ill. Strict bedrest is not necessary. As he recovers from his illness it is permissible to allow him play periods outside in the fresh air. If he is of school age he can return to school after he has not had fever for 24 hours.

If there are questions about your child's illness please feel free to phone the office. Our telephone nurses can help you or relay your question to us.

Antibiotic Drugs

Antibiotics are wonderful and, at time, life-saving weapons in the treatment of certain infectious diseases. Unfortunately, they do not cure all infections, they sometimes cause reactions and they are expensive. The following notes are given o you to help you to understand how we decide whether or not to give your child me of the drugs when he is sick.

As you know, all children get sick. In addition to the usual "childhood diseases," they have many other infections, some of which can be recognized, some of which cannot be recognized. By having such little infections, they gradually build up their resistance and achieve a state of immunity to most disease germs by the time they become adults. Whereas the average adult has only one sickness accompanied by fever every 5 to 10 years, the average young child has 5 to 10 such illnesses each year. Accordingly, we are faced every day with the child who has fever. We examine each of these children to see whether an infection is present which requires an antibiotic drug. If these drugs helped all infections, we could ;imply send you to the nearest drug store where you could pick out a drug according o flavor and color that your child liked.

We know that your child needs these drugs to help him get well from some infections. In other infections these drugs are not needed and may even be harmful. How then do we decide JUST WHEN TO GIVE YOUR CHILD AN ANTIBIOTIC DRUG? In answer there is no single hard an fast rule, but certain criteria are helpful in guiding us. These are:

1. **History and physical examination.** If such examination shows no signs of pneumonia, bronchitis, tonsil, sinus, ear or gland infection, dysentery, kidney infection or meningitis, we have ruled out the majority of the infections which require an antibiotic drug. If, on examination we find only a "little red throat" and your child does not appear too ill, we usually give your child some medicine for fever and restlessness and "sit tight" and watch him. Our decision in such matters can be supported by the following simple laboratory tests.

    a. An examination of the urine will show whether or not an infection of the kidneys or bladder is present.

    b. The white blood count and blood smear help to tell us what type of infection your child has. In general if the white blood count is normal, the chances are that your child has a virus infection which will run its course and resolve without the help of any antibiotic drugs now available.

    c. Other tests such as chest X-ray, may be necessary in certain children to help in locating and evaluating an infection.

2. **"What's Going Around?"** The type of infection prevalent in a community at a particular time of year also may help us in deciding whether or not your child needs Penicillin or one of the other antibiotic drugs. For example, nearly every summer, in July or August, we see a virus throat infection called Herpangina. This infection gets well in 2 or 3 days without help of drugs. On the other hand, there are times when infections such as "strep throat" which requires these drugs become prevalent in our community. Accordingly, when this infection is "going around", the child with the red or sore throat is much more likely to be given Penicillin.

The Common Cold

Every baby and child at one time or another is going to have a common cold. A cold is due to a virus that is caught by the child from the nose or threat of another person.

In general, a cold begins with watery discharge from the nose accompanied by sneezing and watery or "weak" eyes. Some cough, especially at night, may normally accompany the cold. It serves the purpose of keeping the throat and bronchial tubes clear. There may or may not be a slight fever for the first two or three days. By the third or fourth day of the cold, the discharge from the nose usually becomes thicker and the child may be bothered by a stopped up nose, and some increase in the amount of coughing. The cold then gradually runs its course and disappears after five to ten days unless some complications occur.

The treatment or management of a cold consists mainly of measure to make the child more comfortable and to lessen the chances of complications. Medical science has not yet discovered any drug or medicine which cures the cold. Listed below, however, are a few do's and don'ts which you should follow in the management of your child's cold.

- **Do** keep the child's room moist or humid when the air is dry. We recommend the cold air vaporizer or humidifier. By doing so you help keep the cold "loose" and help prevent complications.
- **Do** use nose drops. Normal Saline (salt water) is preferred. (See Nasal Irrigation below.) Us Ayr, Ocean, or other similar brands.
- **Do** give Tempra as directed every 4 hours if the baby is uncomfortable or fretful. It doesn't cure anything, but it may make him feel better.
- **Do not** force him to eat or drink more than he wants. When he has a cold it is normal for his appetite to drop off.
- **Do not** give him a laxative or otherwise try to "work" the cold out of his system. It not only doesn't help, but may even do harm.
- **Do not** start giving him the left over part of an old antibiotic prescription. Those drugs can't cure a cold and their use can do harm and certainly greatly handicap us later if a complication arises.
- **Do not** overdress him or overheat him. A room temperature of 72 to 74 degrees (with added moisture) is plenty warm enough.
- **Do**, as a general rule, keep him indoors for the first several days of his cold.
- **Do** give the runny or stuffy nose medicine by mouth as directed at the first sign of cold. It is no "cure all" but in some infants and children, especially those with allergic tendencies, it may be of considerable help in preventing the development of a complication.

Complications of the Cold

A cold occasionally become complicated, resulting in an ear infection, sinus infection, tonsillitis, or adenoid infection. Actually, there are germs present in everyone's mouth, nose, and throat which are capable of causing infection; under normal circumstances the lining membranes of the mouth, nose and throat resist these germs and prevent infection.

Whenever a cold is present these germs may penetrate the lining membranes, grow and spread and produce infection.

In treating a child's ear, nose or throat infection with antibiotics the drug should be given at regular intervals (as directed) until the child is well. This requires that the drug be given for five to ten days or in some instances even longer. If the drug is stopped too soon, the infection may, in many instances, either flare up again or simply hang on and on.

Treating such an infection may be likened to fighting a fire in that a stream of water (or chemical) must be continued until the fire is completely out. If this is not done and the hose is put away while the fire is still smoldering, the fire may go out by itself. However, the chances are that it will either keep smoldering or else burst once more into flames.

Nasal Irrigation

Many people, especially children whose nasal passages are small, often develop sinusitis and ear infections because of failure to remove the excess mucus and pus in the nasal cavities. The removal of this mucus will often clear the sinus infection, stop the post nasal drainage, and end the cough. To do this nasal irrigation, the following instructions must be followed carefully:

1. Obtain a two-ounce dropper bottle at your drug store. Fill the bottle with warm tap water and add the following as an irrigating solution:
    a. Salt 1/8 teaspoon
    b. Baking Soda (Bicarbonate of Soda) 1/8 teaspoon
2. Blow the nose gently to remove as much mucus as possible. In the case of child too young or unable to blow his nose, us a small rubber nasal syringe and gently suck out the mucus.
3. Put the child on his back with the head hanging way over the bed so that he appears to be standing on his head.
4. Put one medicine dropper full of the irrigation solution in a nostril, sit up and suck this out. Repeat in the other nostril. In the case of a small child, gently use the ear syringe to suck out the fluids. This should be repeated several times until the returns are clear.

This procedure may be done several times a day or used whenever necessary. Following nasal irrigation, if the nose is blocked, one may use a few nose drops such as a Pediatric Afrin. However, you should follow these directions:

- You may use nose drops for five days only.
- You may use these drops twice a day.
- In each nostril us one drop in infants 3 to 12 months, two drops for children 1-2 years, and three drops for children 3-5 years.

If you do not wish to use nasal irrigation, you can use the steam from the shower. Take the child into the smallest bathroom in the house and close the door. While sitting in the room turn on the shower with hot water only. Continue this for 10-15 minutes, you run out of hot water, or you can't stand it any longer; whichever comes first. This accomplishes much of what nasal irrigation will do and is less irritating to the baby.

A Parents' Guide to Rashes

Many childhood illnesses are associated with a rash, and they often cause parental concern. It's a common belief that illnesses with rashes must be worse than those without them. This is usually not so. Rashes can be associated with very serious illnesses or ones that are very mild. Listed below are some of the more common diseases with rashes and a description.

Chicken Pox

This very distinctive rash consists of pea-sized (1/8-1/4") red spots with a large blister in the center. The spots start on the head and torso, then spread to the arms and legs. The primary symptoms are fever and itching. Refer to our web site for further information.

Measles

Measles is on the increase nation-wide, but it is still uncommon. The rash starts after 2-4 days of high fever, a hard cough, and red, draining eyes. The rash is heaviest on the face, chest and back, but also covers the arms and legs. The red spots are about 1/8" across and so thick they tend to run together.

Scarletina

This is the rash associated with strep throat. The spots are pin-point size, rough like sandpaper, very thick, and mainly on the torso. The distinctive characteristic of this rash is that you can often feel it as well as you can see it. Remember though, not all sore throats with a rash are due to strep (see "viral exanthem" below).

Hand, Foot and Mouth Disease

This illness gets its name from the characteristic distribution of the spots. The are small (1/8") oval-shaped flat blisters on the palms and soles and small sores in the mouth and throat. Young infants can also get spots on their bottoms. It is caused by one of the Coxsackie viruses. Fever and a very sore mouth and throat are the main symptoms of the disease.

Fifth Disease (or Erythema Infectiosum)

The rash of Fifth Disease begins as a bright red appearance to the cheeks - they look almost sunburned. As this fades, a lacy-appearing rash spreads down over the upper body. The children are not ill with Fifth Disease. Recently the cause of Fifth Disease has been identified as human parvovirus B 19. There have been a small number of cases where this virus has caused birth defects when pregnant women were infected with it early in their pregnancy. It is therefore advisable that children with this illness be kept away from women who may be pregnant.

Viral Exanthem or Other Viral Rashes

Many of the respiratory, intestinal, and sore throat viruses can be accompanied by a rash. It is usually a fine red rash on the face, chest, and back. It usually appears several days into the illness, often around the time the fever and other symptoms are improving Probably the best known example of this type of rash is Roseola. This virus causes infants to run a fever for 2-3 days with no other symptoms. Around the time the fever breaks, the rash breaks out.

Uricaria or Hives (wheal)

This is another type of rash that can be seen with or following a viral illness. It can also signify an allergic reaction. It itches a lot, but is rarely dangerous. These are only the most common rashes we see. If you are unable to identify with certainty the next rash your child gets, I hope this will at least remove some of the anxiety rashes cause until we can see your child in the office. Although few rashes are an emergency, any rash accompanied by a high fever (102 or over) should be checked within 24 hours. Remember also, unknown rashes and pregnant women in the first 3-4 months do not mix.

Constipation

Constipation is a common problem in infancy and childhood and responds to dietary changes. Among infants there is considerable variability in the normal number of stools per day. Breast fed infants have five or six loose stools per day and on the other extreme an infant may have one stool every two or three days. Both infants may be entirely normal. Straining, grunting and turning red in the face are merely part of the normal physiologic process involved in the act of defecation. Only when the passed stools are extremely hard or the number is extremely irregular should there be cause for concern. Occasionally, when the stools are very firm, definite streaks of blood will be noticed on the outside of the stool specimen. This bleeding is most often caused by a tiny tear in the mucosal lining of the anal region. This is called an anal fissure and is nothing to worry about, unless the bleeding persists. Management of constipation is directed towards softening the stools, either through dietary changes or specific softening agents. Decreasing intake of milk, a frequently constipating food, or increasing dried or fresh fruit intake such as prunes, grapes, peaches or using bran cereal may be of benefit. In infants we usually recommend either prune juice or adding dark Karo syrup to the formula in the initial dose of one teaspoon per bottle of formula. In older children, stool softeners such as Colace or mineral oil may be used. The dose of the mineral oil is one tablespoon per day.

Laxatives and enemas are rarely recommended except prior to diagnostic X-ray procedures. In summary, constipation or infrequent firm hard stools usually respond to dietary changes.

Vomiting

Vomiting very commonly occurs in infancy and childhood. It may accompany many illnesses often unrelated to the digestive system. There are many remedies for the treatment of vomiting. Some will work promptly, some will not. A great deal will depend on the cause of vomiting. If your child looks or acts very ill, if the vomiting persists, if he is having much diarrhea or if there are bloody stools, if there is high fever or if you are worried, be sure and call us at once. For the so-called simple or uncomplicated vomiting or in the beginning before you can be sure about the disease, you may do the following things:

1. Emetrol may help stop the vomiting in some children or you may use 2 oz of chilled Coke to which you add a tablespoon of sugar. Give the child a teaspoon or tow of the emetrol or Coke every 15 minutes for 6-8 doses.

2. Give only "clear" liquids until your child has not vomited for at least six hours. These liquids include: Infalyte, water, weak tea, broth, carbonated beverages, Kool Aid or popsicles. Begin these liquids in small amounts such as a teaspoon or two every 10-15 minutes, gradually increasing the amount up to an ounce or so every half to one hour. You should "feel your way along", taking care not to push to many fluids on the child at one time.

3. If your child does not vomit for six hours, then slowly add to the diet. If he is on a formula, it should be given weakened to half strength by adding equal parts of water. Then such foods as Jello, dry toast, crackers, to older children may be offered. The diet is then gradually increased over the next 12-24 hours, depending on how well the infant or child tolerates food.

By all means we want to be called if the vomiting persists or the child does not seem to be doing well. There are medications such as suppositories which we may prescribe.

Otitis Media

- A growing number of children of working mothers attend day care or preschool centers; 30% of the 9.9 million preschoolers attended day care in 1993, an increase from 23% in 1991.
- Attending group day care increases the risk of acute otitis media threefold. Frequent exposure to respiratory viruses in day care is the initial event in the pathogenesis of AOM.
- AOM is the most common bacterial infection in young children, accounting for more than one-third of all office visits each year.
- AOM is the most common cause of antimicrobial therapy in children, responsible for upward of 31 million visits to doctors and $3 billion to $4 billion in treatment costs.

Risk factors for AOM include:

- first episode at young age
- exposure to tobacco smoke
- gender (boys more likely than girls)
- bottle-feeding
- family history of OM
- attendance in group day care

Consider Safety First

With so much talk of resistance, why should physicians still prescribe amoxicillin?

Physician still recommend amoxicillin for first-line therapy in patients with uncomplicated otitis media because it works most of the time; it is inexpensive and, most importantly, it is safe. Safety is a very important consideration when you are prescribing for conditions like otitis media or sinusitis, which have a very high spontaneous cure rate.

How does a physician choose an alternative is amoxicillin is not working?

If amoxicillin is not working, the concern is that the patient may be infected with an organism that is resistant, for example, one of the organisms that produce B-lactamase. One of the important considerations would be the expanded spectrum of other antimicrobials. Other things a practitioner would take into account would be the taste of the antimicrobial, convenience of dosing and the cost.

How many courses of amoxicillin should the physician try before choosing another drug?

If children with otitis media are given the correct antimicrobial, they will usually have a prompt clinical response in about 72 hours. If they are not getting better at that time, then you need to choose another antimicrobial. You do not give them the full 10 days of medication if they are not better on the third day. They have to improve promptly.

Studies have discussed putting a child with repeat infections on long-term antibiotics, sometime for the entire winter. What are your thoughts on that?

There have been a number of studies that have evaluated children who have a history of recurrent episodes of acute otitis media. When they have been put on antibiotic prophylaxis, that has been successful in reducing the number of symptom- atic episodes ofotitis. Children should be considered eligible for a trial of prophylaxis if they have had three episodes ofotitis media in six months, or four episodes in a year.

When should a physician think about inserting tubes?

The usual motivation for thinking about inserting tympanostomy tubes is hearing loss in the child who has prolonged middle ear effusions (lasting more than three months). A significant hearing loss is a loss of 40 decibels or more, particularly if that loss is bilateral and especially if it occurs in a child who is just acquiring language, say, a child who is between 6 months and 18 months old. If children are not hearing, then you worry that they are not going to acquire language.

With more children being vaccinated with Haemophilus influenzae type b, are you seeing fewer cases ofotitis media caused by non-typeable Haemophilus?

One would not expect the Haemophilus vaccine to have any effect on the frequency of illnesses caused by the non-typeable strain. We do not expect to see fewer cases ofotitis or fewer cases of sinusitis, because the vaccine only prevents systemic disease caused by Haemophilus influenzae type b.

Why do most children seem to outgrow their problems?

One reason they might outgrow otitis is that as they grow, the relationship between the Eustachian tube and the middle ear becomes more favorable for drainage. That may be a helpful factor.

Should a child with repeated cases of otitis with effusion ever be referred to an allergist?

Referral to an allergist should depend on whether the child has any evidence of allergic disease on physical examination. For example, some allergic children will have a little transverse nasal crease from rubbing their noses, or they will have extra transverse lines beneath their eyes (called Dennies lines). When you examine their noses, you may find that their nasal mucosa is pale and boggy. If there is a positive family history of allergic disease, that may be another factor that may influence the practitioner.

Baby Skin Care

Many people think of baby skin as being flawless. In fact, skin is vulnerable to more surface stress between birth and toddlerhood than at any other phase of life. Some irritations can be avoided, treated with simple home remedies, or left to heal by themselves; others require medical care.

Bathing and Shampooing

Keeping your baby's skin and scalp clean is the basis for all skin and hair care. A newborn or very young infant doesn't need a bath every day. Now and then, when a complete bath is skipped, a gentle sponging is sufficient.

In bathing your baby, use temperately warm water (test it with your elbow - it should feel pleasantly warm but not hot) and make sure the room is free of drafts. Use a mild cleansing bar. Rinse all traces of soap away and dry the baby thoroughly, including skin folds. Apply baby ointment, cram, or comstarch (not talcum) powder if desired before diapering.

Gentle washing of your baby's head as part of the bath will suffice until he or she grows enough hair to need a real shampoo. At this point, use a non-irritating baby shampoo, being careful to keep suds away from eyes. For toddlers, a small amount of cream rinse can help in combing out tangles.

Diaper Rash

Diaper rash is quite common, and some babies seem to be more susceptible to it than others. The rash can range from inflammation to pimple-like eruptions or open sores. It results from excessive exposure to moisture, chafing, and the irritating effects of bacteria in urine and stool. Left untreated, diaper rash can progress to infection.

The best way to prevent diaper rash is to change your baby promptly whenever the diaper is wet or soiled. Clean the diaper area carefully with a washcloth or baby wipe, wiping from front to back to avoid spreading bacteria that can cause bladder infections. When the skin is completely dry, you may apply a medicated, comstarch- based baby powder or a soothing cream recommended by your doctor or pharmacist. It's also helpful to let your baby spend some time with a bare bottom to benefit from the healing and drying exposure to air. Avoid plastic or rubberized pants, which trap moisture, and excessive bathing, which can further irritate the skin. For cloth diapers, make sure all soap is rinsed out, and avoid using perfumed fabric softeners or harsh detergents.

If blisters are severe or last for more than a few days, ask your doctor's advice. A zinc oxide ointment may promote healing. Fiery blotches or pustules may indicate a fungal or yeast infection, and your doctor may prescribe an anti-fungal cream.

Newborn Skin

Newborn babies may have a variety of marks or irritations on the skin; almost all are temporary and not serious. Covered with downy hair called lanugo in the womb, babies may be partially or completely covered with hair at birth, and patches of fuzz may remain for a week or so. Some babies are bom with a full head of hair; it breaks easily, which is normal, as are any red blotches around hair follicles.

Finger or feet that were sucked in the womb may sometimes cause a whitish lip blister, called a sucking callus, which may take weeks or months to vanish. The mother's

hormones are present in a newborn, and a mini-puberty with mild acne and a scant menstrual flow in female infants is not unusual. Both newborn boys and girls may have temporary breast and genital enlargement.

It takes a newborn complexion a while to settle down to normal, even tone. At birth, a baby's head and scalp may show signs of bruising from the birth canal. Nothing is more normal than a newborn who is crimson from head to toe, the result of dilated blood vessels, the stress of birth, and a high hemoglobin (red blood cell) count. About half of all infants, including most premature babies, are bom with jaundice, a yellowish cast of the skin and the whites of the eyes. It usually clears up in a few days, sometimes with help from ultraviolet lights before the baby leaves the hospital.

Purplish mottling (from still-unstable blood vessels close to the skin's surface) is common; so are pink marks on the face or neck about the size of a pencil eraser. Black babies are lighter-skinned at birth than they will be later; fingertips and earlobes indicate their true colors. Bluegray marks on the lower back or bottom of most black or Asian babies (and about 10% of white babies) result from dense clusters ofpigmented cells and fade in a year or two.

Newborn Skin Is Also Susceptible To

- **Marks and moles**
  Most parents note each birth mark with concern, but leaving the marks alone is usually the best approach. A mole is the sole exception; since moles occasionally develop into a type of skin cancer called melanoma, they should be routinely checked for any change in size, shape, or color.

- **Thrush**
  This common yeast infection, which appears as a whitish substance inside the baby's mouth about 10 days after birth, may be transferred from a nursing mother who is infected. It can also occur in the diaper area and cause a rash there. Prescription medication clears up the problem.

- **Cradle cap**
  At three or four weeks, some babies develop a scaly, greasy crust on scalp or eyebrows. This infant version of dandruff goes away by itself, although washing with a mild baby shampoo and a washcloth helps.

- **Eczema**
  The bubbling, blisters, and itching of eczema can start about six weeks after birth, and worsen with stress (vaccinations, illness or injury, or teething). Infant eczema usually fades by the third birthday, although childhood eczema sometimes takes its place. Ask for advice on treatment from your pediatrician or from a skin specialist (dermatologist).

Sunburn

Sunburn is a very real hazard to babies, particularly since there is evidence that severe sunburns early in life may predispose to certain types of skin cancer in adulthood. Keep infants out of the sun as much as possible during the first year of life and make sure tender skin is covered with lightweight clothing in summertime sun. For toddlers, an effective sunscreen is essential during long exposures. Sunscreen products are now available formulated especially for children.

Other Skin Problems

Babies and toddlers are subject to many of the same skin conditions that can affect older children and adults. At this age, when skin is so delicate, prompt treatment is very important.

Warts

One out of every 10 children has them at some time, usually on the hands and arms. Warts are cause by a contagious virus, and can be spread from one body part to another by habits such as nail biting. Discourage children from picking at them, if possible. Warts disappear (and recur) over time; your doctor may suggest various methods of chemical or surgical removal.

Scabies

What is scabies?

- Scabies is a highly contagious skin disease caused by a mite too small to see with the naked eye.
- The most common symptom is a rash that itches intensely at night. The rash can be anywhere on your body, but is usually on the hands, breasts, armpits, genital area and waistline.
- Scabies can affect men, women and children of all ages. It is easily spread from person to person by close physical contact, such as between family members, sexual partners and children playing at school. How do I get rid of scabies?
- Your doctor has prescribed a safe and effective treatment called Elimite (permethren) 5% Cream that will eliminate the scabies and relieve the itching.
- To apply, thoroughly and gently massage Elimite Cream into all skin surfaces from your head to the soles of your feet. Be sure that infants and elderly patients are treated for scabies on the neck, scalp, temple and forehead. The cream should be left on overnight for 8 to 14 hours and removed the next morning by bathing and shampooing.
- It is extremely important to put Elimite Cream on every square inch of your body; not just where the rash is. That includes applying it under your fingernails and toenails, around the nail beds, between your fingers and toes, and in the cleft of your buttocks and genital area. If you wash your hands or any other area during the treatment period, new cream must be applied immediately.
- Itching, mild burning and/or stinging may occur after application of Elimite Cream.
- Everyone affected should be treated at the same time, as directed by your physician.
- Be sure to change your clothes and bed linens, and have all the affected articles washed at the same time on a hot cycle or professionally dry cleaned. It is not usually necessary to clean sweaters, jackets, furniture, drapes, or rugs.

- You will not usually be contagious after one treatment if these instructions and your physician's directions have been followed carefully. The scabies mites will be gone in a matter of days; however, the rash and itching may persist up to 4 weeks after treatment. This is rarely a sign of treatment failure and is not necessarily an indication for retreatment. If itching is excessive or if irritation persists, consult your physician.
- Avoid contact with your eyes. If Elimite Cream accidentally gets in your eyes, flush with water immediately.

Ringworm

While not caused by a worm, this fungal condition leaves a characteristic ring-shaped mottled patch. It can be caught from an infected dog or cat or from another person. A contagious but not serious condition, ringworm usually gets better on its own; if not, antifungal ointment or tablets may be prescribed.

Impetigo

This bacterial skin disease is highly contagious. It starts with red spots, usually on the face, which develop into blisters and then fluid-filled pustules that rupture and form crusts. Your doctor will suggest local treatments, such as swabbing the crusts several times a day with an antiseptic solution and washing with medicated soap; antibiotics may also be needed.

Chicken Pox (Varicella)

Chicken pox remains the most contagious infectious rash. Most cases occur in late winter or spring. The peak age is 5-9 years, but may occur at any age. Secondary attack rates among susceptible household contacts is about 90%. The incubation period after exposure varies from 11-21 days, but averages about 14 days in most instances. Children with chicken pox are contagious from 24 hours before the rash appears until all the lesions are crusted (usually 1 week after the rash begins). Your child should not attend school or day care until all lesions are crusted. Generally a child does not develop chicken pox twice.

Chicken pox is characterized by distinctive "tear-top" blisters on red-bases that eventually form scabs. Blisters in the mouth and genital area, fever as high as 105 degrees, malaise, and loss of appetite are common. Itchiness is constant and annoying.

Treatment Of Chicken Pox Includes The Following:

1. Give Benadryl every 4 hours. The dosage is 1 teaspoonful for every 25 pounds of body weight.
2. Wear mittens and keep fingernails short to minimize the effects of scratching.
3. Apply Calamine lotion to the skin. (Do not use Caladryl. Patients frequently become allergic to this).
4. Bathe twice daily in cool water to prevent secondary skin infection. Aveeno Bath (available at the pharmacy) may be added to the bath water to soothe the skin.
5. Change clothing, underwear, and bed linens daily to prevent skin infection.
6. Do NOT give aspirin. A serious disease called Reyes syndrome could result.
7. Treat fever with acetaminophen (e.g. Tempra) according to the following dosage:

- Infant drops (80mg/0.8ml): 1 dropper full for every 10 Ibs. body weight.
- Elixir (160mg/teaspoon): 1 teaspoon full for each 20-30 pounds body weight.
- Suppository (120mg/suppository): 1 suppository for each 18 pounds body weight.

8. Discontinue any steroid medication immediately. If you don't know if a medication is a steroid, ask the doctor. Complications with chicken pox are rare, but your child should be reevaluated by the doctor if he develops any of the following:
    - Severe cough.
    - Skin lesion that appears to be getting infected or become purple or bloody.
    - Incoordination, stumbling, rapid twitching movement of the eyes, or fine shaking of the hands.

Insect Bites or Stings

1. **Bee Stings**
   These stings cause immediate painful red bumps. Although the pain is usually better in 2 hours, the swelling may increase for up to 24 hours. Multiple stings (more than 10) can cause vomiting, diarrhea, a headache, and fever. This is a toxic reaction related to the amount of venom received (that is, not an allergic reaction). A sting on the tongue can cause swelling that interferes with breathing.

   Call our office if:
   - Breathing or swallowing is difficult.
   - Hives are present.
   - There are 10 or more stings.
   - A sting occurs inside the mouth.

   Treatment: If you see a little black dot in the bite, the stinger is still present. Remove it by scraping it off. If only a small fragment remains, use tweezers or a sterile needle just as you would to remove a sliver. Then rub each sting for 15 minutes with a cotton ball soaked in a meat tenderizer solution. This will neutralize the venom and relieve the pain. If meat tenderizer is not available, apply an ice cube while you obtain some.

   Prevention: Some bee stings can also be prevented by avoiding gardens and orchards and by not going barefoot. Insect repellents are not effective against these stinging insects.

2. **Itchy or Painful Insect Bites**
   Bites of mosquitoes, chiggers, fleas, and bedbugs usually cause itchy, red bumps. The size of the swelling can vary from a dot to 1 cm. The larger size does not mean that your child is allergic to the insect bite. Mosquito bites near the eye always cause massive swelling. The following are clues that a bite is due to a mosquito: itchiness, a central raised dot in the swelling, bites on surfaces not covered by clothing, summertime, and the age of the child (that is, he is an infant). In contrast to mosquitoes, fleas and bedbugs don't fly; therefore, they

crawl under clothing to nibble. Flea bites often turn into little blisters in young children. Bites of horseflies, deerflies, gnats, fire ants, harvester ants, blister beetles, and centipedes usually cause a painful, red bump. Within a few hours, fire ant bites change to blisters or pimples.

Treatment

- **Itchy Insect Bites:** Apply calamine lotion or baking soda solution to the area of the bite. If the itch is severe (as with chiggers), apply nonprescription '/2% hydrocortisone cream. Another way to reduce the itch is to apply firm, sharp, direct, steady pressure to the bite for 10 seconds. A fingernail, pen cap, or other object can be used. Encourage your child not to pick at the bites or they will leave marks.
- **Painful Insect Bites:** Rub the area of the bite with a cotton ball soaked in meat tenderizer solution. This will relieve the pain. If you don't have any meat tenderizer, ammonia is a fair substitute. If these substance are not available, an ice cube may help.

Prevention

- **Mosquitoes and Chiggers:** Many of these bites can be prevented by applying an insect repellent sparingly to the clothing or exposed skin before your child goes outdoors or into the woods. Repellents are essential for infants (especially those less than 1 year old) because they cannot bat the insects away.
- **Bedbugs:** The bed and baseboards can be sprayed with 1 % malathion, but young children must be kept away from the area because this substance is somewhat poisonous. You may need to call an exterminator.
- **Fleas:** Usually you will find the fleas on your dog or cat. If the bites started after a move into a different home, fleas from the previous owner's pet are the most common cause. Fleas can often be removed by bringing a dog or cat inside the house for 2 hours to collect the fleas (they prefer the dog or cat to living in the carpet) and then applying flea powder or soap to the animal outdoors. Careful daily vacuuming will usually capture any remaining fleas.

Precautions with DEET Insect Repellents

Insect repellents containing DEET must be used with caution. DEET can be absorbed across the skin into the bloodstream and can cause seizures or coma. Young children may also have reactions to DEET from licking it off the skin. To prevent harmful reactions take the following precautions:

- Apply repellent mainly to clothing and shoes.
- To prevent contact with the mouth or eyes, don't put any repellent on the hands.
- Don't put any repellent on areas that are sunburned or have rashes because the DEET is more easily absorbed in these areas.
- Warn older children who apply their own repellent that a total of 3 or 4 drops can protect the whole body.

- Because one application of repellent lasts 4 to 8 hours, apply it no more than twice daily.
- If repellent is put on the skin, wash it off after child comes indoors.

Call our office if:

- The bites are from fire ants.
- Itching or pain interferes with sleep.
- The bites become infected.

3. Tick Bites

A tick is a small brown insect that attaches to the skin and sucks blood for 3 to 6 days. The bite is usually painless and doesn't itch. The wood tick (or dog tick), which transmits Rocky Mountain spotted fever and Colorado tick fever, is up to Vi inch in size. The deer tick, which transmits Lyme disease, is the size of a pinhead.

Tick Removal: The simplest and quickest way to remove a tick is to pull it off. Use tweezers to grasp the tick as close to the skin as possible (try to get a grip on its head). Apply a steady upward traction until the tick releases its grip. Do not twist the tick or jerk it suddenly because these maneuvers can break off the tick's head or mouth parts. Do not squeeze the tweezers to the point of crushing the tick; the secretions released may contain germs that cause disease. If you have no tweezers, pull the tick off in the same way using your fingers. Some tiny ticks need to be scraped off with a knife blade or the edge of a credit card. If the body is removed but the head is left in the skin, use a sterile needle to remove the head (in the same way that you would remove a sliver).

Prevention: Children and adults who are hiking in tick-infested areas should wear long clothing and tuck the end of the pants into the socks. Apply an insect repellent to shoes and socks. During the hike perform tick checks using a buddy system every 2 to 3 hours to remove ticks on the clothing or exposed skin. Immediately after the hike or at least once daily, do a bare skin check. A brisk shower at the end of a hike will also remove any tick that isn't firmly attached. Because the bite is painless and doesn't itch, the child will usually be unaware of its presence. Favorite hiding places for ticks are in the hair, so carefully check the scalp, neck, armpit, and groin. Removing ticks promptly may prevent infection because transmission of Lyme disease requires 18 to 24 hours of feeding. Also the tick is easier to remove before it becomes firmly attached.

Call our office if:

- You can't remove the tick.
- The tick's head remains embedded.
- A fever or rash occurs in the week following the bite.
- You think your child has some of the symptoms of Lyme disease.
- You think your child has been bitten by a deer tick and it was probably attached for more than 18 hours.

Bronchiolitis

Bronchiolitis is an illness of young infants affecting the entire respiratory tract, but primarily the smallest air passages in the lung (the bronchioles). It is caused by several different viruses which also cause colds and flu-like illnesses. Respiratory syncytial virus, often called RSV, is the most frequent cause and parainfluenza viruses the second most common.

Young children catch these viruses through close contact with others who are infected. Often these are older children and other family members with mild illness or only a cold. The virus is spread when infected mucous is sneezed or coughed into another child's face or onto table tops or objects such as toys. Infection occurs when the child touches these surfaces and then his/her eyes or nose. Illness begins about 3 to 7 days later.

Bronchiolitis usually starts as a cold, accompanied by fever and nasal stuffiness. After 2 to 4 days the virus spreads down the bronchioles, causing irritation and narrowing of these air passages. This causes the child to cough and produce a whistling sound (wheeze) when breathing out. Some children appear to be having an asthma attack as their breathing becomes more rapid and labored and the cough more juicy or hoarse ("croupy"). Fever may still be present but has often disappeared by this time. Most children have a poor appetite and infants may have difficulty sucking, especially for prolonged periods. Restless sleep with frequent awakening is common.

Wheezing usually gets better after 3 to 5 days; however, nasal stuffiness may last longer and cough may persist for another 1 or 2 weeks. You should call our office if you feel frightened or worried about your child's illness.

Call our office right away if your child has: increasing difficulty breathing; sever sucking in of the spaces between the ribs with each breath; very fast breathing (over 60/ minute); a bluish tinge around the lips; difficulty staying awake. Call us during regular office hours (or on weekends) if your child: refuses to drink; has fever over 102 degrees; complains of an earache or, in an infant, pulls at the ears or becomes increasingly cranky.

Most infants with bronchiolitis do not need specific medications but rather require patience and care to make breathing and drinking less difficult. Using a vaporizer or humidifier in the room where the child sleeps will help keep nasal secretions moist and the nasal passages clear. Cold water vaporizers are preferable; those using hot water can cause bums if pulled over by an inquisitive infant or toddler. The nose may be suctioned every few hours with a rubber bulb (called an ear syringe), especially prior to feeding and sleeping. Saltwater nose drops (1/4 teaspoon table salt in 1 cup of water) placed in the nasal passages before suctioning will help liquify and clear the secretions. Elevating the head of the bed or crib during sleep may also improve the clogging of the nasal passages.

If your child appears to have difficulty feeding or sucking, offer smaller feedings more frequently. It is more important to drink liquids, such as juice or soft drinks, than to eat solid food during the early part of the illness.

Acetaminophen (e.g. Tempra, Tyienol, Panadol, Liquiprin) can be used for fever over 101 degrees. Aspirin should not be given to children with viral infections. Do not give your child any medicines for colds or asthma without first checking with your doctor; they could be harmful.

Because bronchiolitis is cause by viruses, antibiotics are of no use. Your child may, however, need antibiotics if she/he has an associated bacterial infection such as an ear infection.

You generally do not need to restrict your child's activity. Most children will adjust their activity according to how they feel.

Children with bronciolitis are most apt to spread the virus to others during the first days of their illness when they have fever and coldlike symptoms, especially sneezing and coughing. Mucous secretions from the nose and mouth can, however, be contagious for a week or more.

Little can be done to prevent young children from spreading or acquiring viral respiratory infections. Disposing the dirty facial tissues promptly and properly, along with good handwashing, can help prevent spread of infection among family members.

Infants and young children can return to day care or other group activities when they have no fever feed normally and feel well. A lingering cough or runny nose is no reason to keep them at home.

Coughing helps your child clear the airways and should not be suppressed with strong cough medicines. Overly vigorous us ofdecongestants for treatment of nasal stuffiness should also be avoided. These drugs may make the secretions thick and can have unwanted side effects in young children.

A small object inhaled into the lungs can occasionally cause wheezing which sounds just like bronchiolitis. If difficulty breathing occurred suddenly or if your child was playing with a small object right before the illness began, let your doctor know.

Scoliosis

What is scoliosis?

Scoliosis is a "side to side" curve of the back. It is a deformity of the spinal column or backbone.

What causes scoliosis?

Most scoliosis is of unknown cause ("idiopathic"). Recent studies suggest that heredity does play a part in these cases. Therefore, if a person is found to have scoliosis, other family members should also be checked.

Who is affected by scoliosis?

Anyone can be affected by scoliosis. Onset usually occurs between the ages of 10 and 13, when the child begins the rapid growth spurt. Scoliosis can affect members of both sexes, but occurs more frequently in females, who account for approximately 85% of the cases.

Why is screening for scoliosis important?

It is most important to detect the condition as early as possible so that treatment can be provided. Without treatment, undetected scoliosis can get worse rapidly during the growing years and result in physical deformity, limitation of physical activity and other more serious complications.

What are the signs of scoliosis?

Frequent signs are a bump over the shoulder blade; one shoulder or hip higher than the other; unequal distance between the arms and body, and clothes that "don't hang right." These signs are not always noticed and can be easily mistaken for poor posture.

What is the treatment for scoliosis?

In many instances of mild curvature, periodic supervision by a doctor is all that is necessary. When medical treatment becomes necessary, an orthopedic surgeon (bone specialist) may recommend braces or surgery depending on the condition. Regular follow-up while the child is wearing the brace is important. The doctor may prescribe a daily exercise an fitness program to maintain the muscles in goo shape and promote a sense of well being, but exercise alone will not correct the problem. Electrical stimulation in lieu of braces appears to be a promising alternative. However, this type of treatment is very expensive and is still considered experimental. When other methods have failed or the scoliosis is severe, surgery may be necessary. After the operation, the child will need to wear a cast or brace for a number of months and continue to be supervised by an orthopedic surgeon. The remaining disability may be minimal and the patient may lead a normal life after recovery.

Are schools required to provide screening?

House Bill 832 passed by the Texas Legislature in 1985 requires screening for abnormal spinal curves in grades 6 and 9 (5 and 8 or 6 and 8). If a child shows any signs of a possible deformity, the school is required to notify the parents.

What can parents do?

If notified that their child may have an abnormal spinal curve, parents should take their child to the doctor for a diagnosis. Parents can also leam to check their child for a curve of the spine. If they suspect that their child may have a problem, they may check with the school nurse, the health department of their private doctor.

Middle Ear Infections

Middle ear infections

Infections and obstructions of the middle ear are very common in the infant and young child. The ultimate aim of treatment of these conditions is to leave THE CHILD'S HEARING APPARATUS UNDAMAGED. Various measure may be used in the treatment of your child's ear trouble including ear drops, pain relieving drugs, nose drops, antibiotic drugs, and on rare occasions, opening or lancing the ear drum. Some knowledge of the ear, how it works, and how it gets infected helps the parent to understand the various treatment principles which may be necessary in their child's ear infection.

What part of the ear ususally gets infected?

The middle ear.

How does the infection get into the middle ear?

Through a little tube which runs from the throat back behind the nose over the middle ear. This tube is called the Eustachian Tube.

How can a parent know when a young baby has an earache?

The baby usually — but not always cries out in pain or is fretful. He may rake or bat at his ears. He may cry especially on coughing, sneezing, yawning, sucking, or swallowing. If the baby acts as though he has a sore throat and takes only a suck or two from the bottle then cries, it is usually due to pain in the middle ear, set up because of the pressure change caused in the tube when the baby sucks. A child with an ear infection also frequently has vomiting and loose bowels. Remarkably enough, in some instances, especially when the ear infection or obstruction come on slowly, the baby may have no symptoms whatsoever even though the middle ear may be full of fluid or pus. If an ear infection goes untreated, there may be rupture of the eardrum or destruction of the sound transmitting apparatus of the middle ear.

How is an ear infection treated now?

1. An antibiotic drug is given regularly for a period of 10 days or longer until the infection is well and the ear drum has returned to normal.
2. Ear drops. These are useful in certain patients for the relief of pain.
3. Tempra or other pain-relieving medicine may be used when indicated.
4. The eardrum may need to be opened in rare cases.
5. It is most important to re-examine an infected ear 10-14 days after the infection to insure complete cure and that there is no residual fluid in the middle ear space which could affect the hearing.

Why do some infants and young children have so much ear trouble?

Factors which predispose the young infant to ear trouble are:

1. The Eustachian tube is shorter and more horizontal in children than adults, allowing mucus and infection to more readily spread to the middle ear space.
2. The young child has less resistance to infection.
3. The infant and young child have larger adenoid tissue. The adenoid tissue grows in the back of the throat right by the opening of the Eustachian tube, thereby blocking it.
4. Young infants who have nasal allergy who "keep a cold", stuffy or runny nose, rattle in their throat, and swollen adenoids, are particularly apt to have ear trouble.

What can I do to keep my young infant or child from having ear trouble?

1. Do not smoke around your child.
2. Do not allow child to take a bottle while lying down.
3. Minimize exposure to other sick children as much as possible.
4. In some circumstances, use of a preventative antibiotic may be indicated.
5. If problems persist, referral to an Ear, Nose and Throat surgeon may be indicated. The surgeon may recommend ear ventilation tubes and/or the removal of adenoidal tissue. If this problem seems to be a result of allergies, an allergy evaluation may be indicated.

Swimmer's Ear

Swimmers ear, a type of Otitis Extema, is a common ailment for those who swim. It can be quite painful. It is an inflammation and infection of the outer ear canal. When the ears are frequently immersed in water, the ear wax can be dried, washed away or can trap water within the ear. The increase in moisture along with loss of the protective layer of wax can cause the ear canal to be a place for infection to begin.

Treatment always includes ear drops and may include ear washes and wicks. If the canal is somewhat clear of infected material, drops may be the only treatment. These are to be used four times daily for five days. If the canal is blocked with wax and infected material, the canal may be washed so that the drops can reach the infected area. Earwicks are placed down the canal. They absorb the drops and help the medication come in contact with the canal walls and areas near the eardrum. If a wick is used, it is important that it stays in at least 24 hours. If it falls or is pulled out during the first day, call the office. If it hasn't fallen out in three days, gently pull it out.

One week after your visit we need to re-check your (your child's) ears to insure healing. Swimming IS NOT allowed during treatment. Keeping the ears dry helps in preventing future external ear infections. After swimming, dry the ears well.

Strep Throat

A common cause of sore throats in both children and adults is a germ called the streptococcus or the "strep" germ.

The strep germ can cause disease of varying severity in different individuals. Some infections may be mild while others may cause severe sore throats, enlarged glands in the neck and scarlet fever.

The strep germ is contagious especially among children in the same school room or among different members of the same family. Not infrequently we will have a situation in which one child in a family has scarlet fever, another has a slight sore throat, a third, especially a young infant, may have only a runny nose, yet all are infected by the same germ. It is important to get rid of the streptococcus — not only to get the sick child well, but also to prevent the development of rheumatic fever or acute nephritis (kidney disease). These complications occur in certain individuals approximately 3 weeks after a strep infection, especially if the germ is not promptly and completely eradicated.

Diagnosis: The diagnosis of strep throat is made by physical examination and at times a white blood count and/or throat swab is necessary to confirm the diagnosis. We can now do rapid testing for strep on a throat swab is necessary to confirm the diagnosis. We can now do rapid testing for strep on a throat swab that takes only a few minutes.

Treatment: Fortunately, the strep is very sensitive to many of the antibiotic drugs and particularly Penicillin. A shot of Penicillin or a few doses of Penicillin by mouth will usually bring the child's temperature to normal and help in getting rid of most of the symptoms - HOWEVER, IN ORDER TO KILL OUT THE GERM COMPLETELY IT IS NECESSARY TO MAINTAIN A LEVEL OF ANTIBIOTIC IN THE INDIVIDUAL'S BLOOD FOR A MINIMUM OF TEN DAYS. If treatment is stopped short of this time, the relapse rate is high, complications may occur or the whole process of treatment may have to be repeated. This is the reason we sometimes treat strep throat with a long acting

Penicillin shot called Bicillin. It's important to remember that not all sore throats with fever are due to strep. Many viruses can cause similar symptoms. A throat swab can help to confirm the diagnosis if there are any questions.

Return to daycare or school: Your child may return after he has been treated with antibiotic for at least 24 hours and is symptom free.

Accident Prevention

What to do in case of poisoning

You may call poison control directly at 784-5030.

Save container and any material left in the container for us. Give us the name of the product and its contents. In case you can not reach one of us immediately, take the child to the nearest hospital emergency room.

Emergency Measures:

1. Induce vomiting by giving Syrup of Ipecac as directed EXCEPT when patient
    a. is having convulsions.
    b. has swallowed kerosene, gasoline, furniture polish, lighter fluid.
    c. has swallowed Lye (drain cleaners, etc.) or acid (toilet bowl cleaners, etc.)
2. If patient has swallowed Lye (drain cleaners, automatic dishwasher detergent, etc.) or swallowed acid (toilet bowl cleaners, etc.). DON'T give anything by mouth, CALL US.
3. If patient has inhaled a poisonous gas:
    a. Carry patient to fresh air.
    b. Apply artificial respiration if breathing has stopped.
    c. Keep patient quiet and warm.
4. If toxic substance is on clothing and/or skin.
    a. Remove contaminated clothing.
    b. Rinse contaminated area thoroughly with water (shower, hose, or faucet).
5. If irritating substances get into eyes, hold eyelids open and wash with gentle stream or running water immediately.

REMEMBER THAT THE BEST TREATMENT OF ANY KIND OF POISONING IS PREVENTION -LOCK UP ALL DANGEROUS CHEMICALS AND MEDICATIONS

Accident Prevention

Nearly half of all child hood deaths result from accidents. A more accurate term is "preventable injuries." Accidents don't just happen: they result from circumstances and events that come together with unfortunate results. Your responsibility as a parent is to protect your child from hazards and, as he or she grows older, to teach safety precautions and enforce safety rules. There are many tips and gadgets to help "childproof a home, but the one most important factor in your child's safety is you. The following safety measures are the most vital ones for babies, preschoolers, and very young school-age children.

Car Safety

Among all childhood accidents, the greatest number involve automobiles. Use properly installed, age-appropriate car seats each and every time your child is in a car, until your child is 5 years old or 40 pounds, then use a seat belt. (Use your seat belt-provide a good example). A baby is not safe in your lap in a collision. Never leave a child unattended in a car. Using a car seat correctly makes a big difference. Even the "safest" seat may not protect your child in a crash unless it is used correctly.

Does your car have a passenger air bag?

- An infant in a rear-facing seat should NEVER be placed in the front seat of a vehicle that has a passenger air bag.
- The safest place for all children to ride is in he back seat.
- If an older child must ride in the front seat, move the vehicle seat as far back from the air bag as possible and buckle the child properly.

Is your child facing the right way for both weight and age?

- Infants should ride facing the back of the car until they have reached at least 1 year of age AND weigh at least 20 pounds (A and B).
- A child who weighs over 20 pounds AND is older than 1 year of age may face forward.

Has your child grown too tall for the convertible or forward-facing seat or has your child reached 40 pounds?

- Use a belt-positioning booster seat to help protect your child until he is big enough to use a seat belt properly.
- A belt-positioning booster seat is used with a lap and shoulder belt.
- Shield boosters, used only with lap belts, are not safe for children over 40 pounds. Children under 40 pounds should use a convertible or forward-facing seat. Shield boosters should only be used without the shield with a lap/shoulder belt.

Have you tried the car seat in your vehicle?

- Not all car seats fit in all vehicles.
- When the car seat is installed, be sure it does not move side-to-side or toward the front of the car.
- Be sure to read the section on car seats in the owner's manual for your car.

Is the seat belt in the right place and pulled tight?

- Route the seat belt through the correct path (check your instructions to make sure), kneel in the seat to press it down, and pull the belt tight.
- A convertible seat has two different belt paths, one for infants and one for toddlers.
- Check the owner's manual for your car to see if you need to use a locking clip or a tether to keep the safety seat secure.

Is the harness snug, does it stay on your child's shoulders?

- The shoulder straps of the car seat go in the lowest slots for infants riding backward, and in the highest slots for children facing forward.
- The chest clip should be placed at armpit level to keep the harness straps on the shoulders.
- Harnesses should fit snugly against your child's body. Check the instructions on how to adjust the straps.

Do you have the instructions for the car seat?

- Follow and keep them with the car seat. You will need them as your child gets bigger.
- Be sure to send in the registration card that comes with the car seat. It will be important in case your car seat is recalled.

Has your child's car seat been recalled?

- Call the Auto Safety Hotline (888/DASH-2-DOT) for a list of recalled seats that need repair.
- Be sure to make any necessary repairs to your car seat.

Has your child's car seat been in a crash?

- If so, it may have been weakened and should not be used, even if it looks all right.
- Call the car seat manufacturer if you have question about the safety of your seat.

Children should be taught proper street crossing procedure early, but should not be allowed to cross alone until they've done so with the parents hundreds of times. Young children should never be allowed to play or ride bicycles in or near the street. Safety experts discourage the use ofchildseats for adult bicycles, and many young passengers have sustained serious injuries. If you do use a bike seat, be sure the child wears a protective helmet and safety harness or belt.

Home Safety

Many child hood injuries happen at home, especially to babies, and toddlers. In "child-proofing" your home from a curious toddler, it helps to get down on your hands and knees to view hazards (and temptations) from your child's perspective. These are key areas for accident prevention. Use the following checklist to help insure your home is safe for your child!

Your Child's Bedroom

- Is there a safety belt on the changing table to prevent falls?
- Is the baby powder out of baby's reach during diaper changing? Inhaled powder can injure a baby's lungs. Use comstarch rather than talcum powder.
- Are changing supplies within your reach when baby is being changed?
- Never leave a child unattended on a changing table, even for a moment.
- Is there a carpet or a nonskid rug beneath the crib and changing table?
- Are drapery and blind cords out of the baby's reach from the crib and changing table? They can strangle children if they are left loose.
- Have bumper pads, toys, pillows, and stuffed animals been removed from the crib by the time the baby can pull up to stand? If large enough, these items can be used as a step for climbing out.
- Have all crib gyms, hanging toys, and decorations been removed from the crib by the time your baby can get up on his hands and knees? Children can get tangled in them and become strangled.
- Make sure the crib has not elevated comer posts or decorative cutouts in the end panels. Loose clothing can become snagged on these and strangle your baby.
- Does the mattress in the crib fir snugly, without any gaps, so your child cannot slip in between the crack and the crib side?
- The slots on the crib should be no more than 2 Vi inches apart. Widely spaced slots can trap an infants head.
- Are all screws, bolts, and hardware, including mattress supports, in place to prevent the crib from collapsing?
- Make sure there are not plastic bags or other plastic material in or around the crib that might cause suffocation.
- Check the crib for small parts and pieces that your child could choke on.
- Make sure the night-light is not near or touching drapes or a bedspread where it could start a fire. Buy only "cool" night-lights that do not get hot. Is there a smoke detector in or near your child's bedroom?
- Make sure that window guards are securely in place to prevent a child from falling out the window. Never place a crib, playpen, or other children's furniture near window.
- Are there plug protectors in the unused electrical outlets? These keep children from sticking their fingers or other objects into the holes.

- Make sure a toy box does not have a heavy, hinged lid that can trap your child. (It is safer with no lid at all.)
- To keep the air moist, use a cool mist humidifier (not a vaporizer) to avoid bums. Clean it frequently and empty it when not in use to avoid bacteria and mold from growing in the still water.
- To reduce the risk of SIDS (Sudden Infant Death Syndrome), put your baby to sleep on her back in a crib with a firm, flat mattress and no soft bedding underneath her.

Your Bedroom

- Do not keep a firearm anywhere in the house. If you must, lock up the gun and the bullets separately.
- Check that there are no prescription drugs, toiletries, or other poisonous substances accessible to young children.
- If your child has access to your bedroom, make sure drapery or blind cords are well out of reach. Children can get tangled in them and become strangled.
- Is there a working smoke detector in the hallway outside of the bedroom?

The Bathroom

- Is there a nonskid bath mat on the floor to prevent falls?
- Is there a nonskid mat or no-slip strips in the bathtub to prevent falls?
- Are the electrical outlets protected with Ground Fault Circuit Interrupters to decrease the risk of electrical injury?
- Are medications and cosmetics stored in a locked cabinet well out of your child's reach?
- Are hair dryers, curling irons, and other electrical appliances unplugged and stored well out of reach? They can cause bums or electrical injuries.
- Are there child-resistant safety latches on all cabinets containing potentially harmful substances (cosmetics, medications, mouthwash, cleaning supplies)?
- Are there child-resistant caps on all medications, and are all medications stored in their original containers?
- Is the temperature of your hot water heater 120 degrees or lower to prevent scalding?
- Do you need a doorknob cover to prevent your child from going into the bathroom when you are not there? Teach adults and older children to put the toilet seat cover down and to close the bathroom door when done - to prevent drowning.
- Remember, supervision of young children is essential in the bathroom, especially when they are in the tub - to prevent drowning. Never leave a baby or toddler unattended in the bath, even for a moment. If you must leave, take your child with you.

The Kitchen

- Make sure that vitamins or other medications are keep out of your child's reach. Use child-resistant caps.
- Keep sharp knives or other sharp utensils well out of the child's reach (using safety latches or high cabinets).
- See that chairs and step stools are away from counters and stove, where a child could climb up and get hurt.
- Use the back burners and make sure pot handles on the stove are pointing inward so your child cannot reach up and grab them.
- Make sure automatic dishwasher detergent and other toxic cleaning supplies are stored in their original containers, out of a child's reach, in cabinets with child safety latches.
- Keep the toaster out of your child's reach to prevent bums or electrical injuries.
- Keep electrical appliances unplugged from the wall when not in use, and use plug protectors for wall outlets.
- Are appliance cords tucked away so that they cannot be pulled on?
- Make sure that your child's high chair is sturdy and has a seat belt with a crotch strap.
- Is there a working fire extinguisher in the kitchen? Do all adults and older children know how to use it?

The Family Room

- Are edges and comers of tables padded to prevent injuries?
- Are houseplants out of your child's reach? Certain houseplants may be poisonous.
- Are televisions and other heavy items (such as lamps) secure so that they cannot tip over?
- Are there any unnecessary or frayed extension cords? Cords should run behind furniture and not hang down for children to pull on them.
- Is there a barrier around the fireplace or other heat source?
- Are the cords from drapes or blinds kept out of your child's reach to prevent strangulation?
- Are plug protectors in unused electrical outlets?
- Are matches and lighters out of reach?

Miscellaneous Items

- Are stairs carpeted and protected with non-accordion gates?
- Are the rooms in your house free from small parts, plastic bags, small toys, and balloons that could pose a choking hazard?
- Do you have a plan of escape from your home in the event of a fire? Have you reviewed and practiced the plan with your family?

- Does the door to the basement have a self-latching lock to prevent your child from falling down the stairs?
- Are dangerous products stored out of reach (in cabinets with safety latches or locks or on high shelves) and in their original containers in the utility room, basement, and garage?
- If your child has a playpen, does it have small-mesh sides (less than ^A mesh) or closely spaced vertical slats (less than 2 Vi inches)?
- Are the numbers of the Poison Control Center and your pediatrician posted on all phones?
- Do your children know how to call 911 in an emergency?
- Inspect your child's toys for sharp or detachable parts. Repair or throw away broken toys.

The Playground

- Are the swing seats made of something soft, not wood or metal?
- Is the surface under playground equipment energy absorbent, such as rubber, sand, sawdust (12 inches deep), wood chips, or bark? Is it well maintained?
- Is your home playground equipment put together correctly and does it sit on a level surface, anchored firmly to the ground?
- Do you check playground equipment for hot metal surfaces such as those on slides, which can cause bums? Does your slide face away from the sun?
- Are all screws and bolts on your playground equipment capped Do you check for loose nuts and bolts periodically? Be sure there are no projecting bolts, nails, or s-links.
- Do you watch your children when they are using playground equipment - to prevent shoving, pushing, or fighting?
- Never let a child play on playground equipment with dangling drawstrings on a jacket or shirt.

The Pool

- Never leave your child alone in or near the pool, even for a moment.
- Do you have a 4-foot fence around all sides of the pool that cannot be climbed by children and that separates the pool from the house?
- Do fence gates self-close and self-latch, with latches higher than your .child's reach?
- Does your pool cover completely so that your child cannot slip under it?
- Do you keep rescue equipment (such as a shepherd's hook or life preserver) and a telephone by the pool?
- Does everyone who watches your child around a pool know basic lifesaving techniques and CPR?
- Does your child know the rules of water and diving safety?

- Keep containers that might fill up with water covered. Infants can drown in a few inches of water. Pools and open toilet bowls present similar danger.

The Yard

- Do you use a power mower with a control that stops the mower if the handle is let go?
- Never let a child younger than 12 years of age mow the lawn? Make sure your older child wears sturdy shoes (not sandals or sneakers) while mowing the lawn and that objects such as stones and toys are picked up from the lawn before it is mowed.
- Do not allow young children in the yard while you are mowing.
- Teach your children to never pick and eat anything from a plant.
- Be sure you know what is growing in your yard so, if your child accidentally ingests a plant, you can give proper information to the Poison Control Center.

Fire and Burns

In house fires, smoke causes more injuries and deaths than flames. That's why smoke detectors are needed in all sleeping areas and should be tested regularly to make sure they work. Keep a fire extinguisher in or near the kitchen. The entire household should follow fire safety precautions (like not smoking in bed, and keeping all smoking materials, including lighters, out of children's reach). A family fire escape plan should be established and fire drills should be practiced regularly.

Two easily overlooked bum hazards are scalding (a bum from hot liquids) and electricity. Never leave pots, coffee makers, kettles, or containers of hot food or beverage within reach or near the edge of counters or tabletops. Never eat or drink anything hot near or while carrying the baby. Do not smoke near the baby. Set the water heater to a maximum of 120 degrees to prevent tap water scalds. (The hotter the water, the shorter time necessary to scald!) And keep extension cords out of reach and electrical outlets capped or covered.

Teach the meaning of the word "hot" to infants 7-9 months of age. Until they can fend for themselves, keep radiators, heaters and stoves off-limits.

Choking and Strangulation

Babies are helpless and unable to move away from an object that blocks their breathing. It's up to you, therefore, to make sure that no such objects, cross their paths. Crib mattresses should be tight-fitting, and crib slats no more than 2 3/8 inches apart, with no cutout designs or comer posts that might catch clothing. BEWARE OF ANTIQUES. Keep Venetian blind cords and dry cleaner's bags far from the crib.

Toddlers are prone to choking on small objects and food. Keep small toys, party balloons (including broken ones), game pieces, pen caps, buttons, marbles, leggo pieces, and other such items out of reach. Also, avoid feeding hard or round pieces of food to children under four, including: peanuts, hot dogs, raw carrots, popcorn, raisins, grapes, chunks of peanut butter, hard candies, gum, and hard fruits or vegetables. Cut food into small soft pieces.

Falls

Don't leave an infant unattended, even briefly, on a bed, changing table or sofa. Babies can and will roll or wriggle off. Once a child becomes mobile, place securely installed safety gates at the top and bottom of stairs, and use them until the child is old enough to climb them or push them over. Keep stairways well-lit, in good repair, and free of clutter.

Install window guards or opening stops in all accessible windows; a baby needs an opening of just five inches to crawl through. Screens aren't strong enough to restrain a child. Move furniture and other climbing aids away from unguarded windows.

Trampolines

Trampolines are often described as fun for kids and a great way to get exercise. However, an estimated 83,000 people were injured on trampolines in 1996, more than double the number of people injured in 1990. Most of these injuries happened on home trampolines. The American Academy of Pediatrics recommends that trampolines never be used at home, in routine gym class, or on playgrounds.

Trampolines can be very dangerous

Most of the people injured from trampolines are children ages 5 through 14. Common injuries include:

- Broken bones (often needing surgery)
- Concussions and other head injuries
- Neck and spinal injuries
- Sprains/strains
- Bruises, scrapes and cuts

How children are hurt

Children can be hurt on trampolines in a lot of ways. Most injuries happen from:

- Falling off the trampoline
- Landing wrong while jumping
- Attempting stunts
- Colliding with another person on the trampoline
- Landing on the springs or frame of the trampoline

Trampolines should be used only in supervised training programs for gymnastics, diving, or other competitive sports and only under the direct supervision of a professional trained in trampoline safety. Don't risk it! Trampolines should never be used at home, in gym classes, or on the playground!

Head Injuries

Head injuries can have serious and long-lasting consequences. However, head injuries can be prevented or minimized by taking proper precautions.

An article in the September 8,1999, issue of JAMA reports on the recommendations of a panel of experts regarding rehabilitation therapy for people who have experienced traumatic brain injury (brain injuries cause by trauma, such as vehicle crashes, firearms,

falls, violent assaults, or sports injuries). The panel recommends that rehabilitation services be matched to each individual's special needs and that the patients and their families should play an important role in the planning and design of the therapy program.

Types Of Head Injuries

- Concussion
  Confusion or brief loss of consciousness following a violent blow or other trauma to the head
- Fracture
  A break or crack in the bony covering of the brain (the skull). Usually indicates a major blow to the head and may include damage to the brain. However, serious brain inj uries can occur without the skull being fractured.

Serious Effects Of Head Injuries

- Swelling
  Swelling of brain tissue after trauma to the head, causes pressure on the brain.
- Hemorrhage
  Bleeding inside or around the brain, cause pressure on the brain and can compress or directly damage brain tissue.
- Hematoma
  Blood clot that forms within or around the brain, causes pressure on the brain.
  All head injuries are potentially serious and should be evaluated by a doctor.

Symptoms After Head Injuries

The following symptoms after a head injury call for immediate medical evaluation:

- headache
- disorientation and confusion
- loss of consciousness
- loss of memory of events surrounding injury
- dizziness
- blurred vision or double vision
- difficulty swallowing
- slurred speech
- nausea
- vomiting

Burn Injuries

Each year in the United States, more than 2 million people require medical attention for bum injuries. About half of these injuries affect children. Major advances in the treatment of bum injuries have made it possible to save the lives of children with severe bums. A study in the January 5,2000, issue of JAMA reports that children who suffer bums to more than 70% of their bodies often are able to recover sufficiently to enjoy a decent quality of life. Although some surviving children had lingering physical disability, most benefited from comprehensive bum care.

Preventing Burns

- Keep children at a safe distance from hot liquids and other hot sources.
- Set your home water temperature heater at 120 degrees or lower.
- Avoid using a tablecloth if you have toddlers at home (they may pull on it and cause hot objects on the table to fall).
- Make sure babies and older children sleep in flame-retardant sleepwear.
- Teach older children about fire safety and how to get out of the house safely in case of a fire.
- **In the Kitchen:**
    - While cooking, keep young children in a high chair or playpen, at a safe distance from hot surfaces, hot liquids, and other kitchen hazards.
    - Use extra caution if you use a deep fat cooker or fryer when children are around.
    - Keep appliance cords away from edge of counters, and keep them unplugged and disconnected when not being used.
    - Keep pot handles turned in so pots cannot be pulled or knocked of the stove.
- **Microwaves:**
    - When heating food for a young child, sample the food for temperature safety before feeding it to the child.
    - Keep children away from the microwave and other heating appliances when removing hot food.
    - Do not hold a child in your arms while removing items from the microwave.
    - Heating baby formula or milk in bottles with disposable plastic linings may be dangerous because the liner may burst. Using a baby bottle warmer may provide a safer way to heat baby bottles.
- **Matches and lighters:**
    - Don't leave cigarettes, matches, or lighters unattended and keep them out of sight and out of reach of young children.
    - Children should be taught that cigarettes, matches, and lighters are not toys and they should never play with them.

Types of Burns

- First-degree
  Bums that affect only the outer layer of skin (epidermis).
- Second-degree
  Bums that damage the first and second layer of the skin (dermis).
- Third-degree
  Bums that damage the skin to its full depth and damage the underlying tissues; often requires skin grafting (surgery to replace the skin).

What To Do For Major Burns

Bums can be thermal (caused by contact with open flames, hot liquids, hot surfaces, and other sources of high heat), chemical (caused by detergents, cleaning agents, bleach, or other chemicals) or electrical. For a major bum it is important to:

- Stop the burning. Remove the child from the bum source.
- For thermal and some types of chemical burns (except those cause by dry chemicals), flush the skin with cold water.
- Check breathing
- Cover the bum with a sterile pad or clean sheet.
- Get the child immediately to the nearest hospital for medical attention.

Firearm Injury and Death

1. A firearm in the home is more likely to result in a death during a household quarrel, a suicide attempt, or an unintentional shooting than in protecting members of the household.
2. Firearms are especially dangerous in homes where children are living, someone in the house abuses alcohol or other drugs, there is a person with depression, or there is any family violence.
3. If a firearm is kept in the home it should be kept unloaded and securely stored locked up, with ammunition stored separately.
4. Children should be taught never to play with firearms anywhere and to seek and adult immediately if they encounter one.
5. Parents should ask about the presence and accessibility of firearms in homes their children will be visiting and restrict visits to homes that are not safe.
6. Firearms that are no longer desired should be turned in to local law enforcement authorities or rendered unusable, but only by a professional properly trained to render the firearm inoperative and safe.
7. Children and adolescents should be taught to resolve conflicts nonviolently.
8. Parents should monitor children's use of television and other media and block access to messages that glorify firearm use or justify irresponsible firearm use. If children are exposed to such messages, parents should draw attention to the behaviors as undesirable and/or maladaptive and highlight the suffering caused to victims and their loved ones.

9. Family members should remove firearms from the home when a member becomes depressed, develops a major mental illness, has a drug or alcohol problem, or is exhibiting memory problems.
10. Family members should remove firearms from the home if there is an escalating pattern of family violence.
11. Patients should discuss firearm safety and health-related issues with their doctors and other health care providers.
12. If the decision is made to own a firearm, be sure to leam all about handling, storing, securing, cleaning, carrying, and firing of the weapon safely.

Lyme Disease

If you are bitten by a deer tick and it stays on you for 48 hours, there's a small chance that you could acquire Lyme disease. Early detection and treatment with antibiotics will readily cure it, but determining whether someone has Lyme disease can be difficult because the symptoms can resemble other illnesses. If you suspect that anyone in your family has Lyme disease, contact our office.

Symptoms

- Erythema migrate (EM)
  A red rash, it is usually the first symptom of Lyme disease. The red rash usually starts at the site of the tick bite and can expand over a period of days to weeks. EM is usually accompanied by fever, stiff neck, body aches, and fatigue.
- Arthritis
  After several months, about half of the infected people who are not treated develop recurrent attacks of painful and swollen joints that last a few days to a few months. About 10% to 20% of untreated people go on to develop chronic arthritis.
- Neurological symptoms
  Lyme disease also can affect the nervous system, causing such symptoms as stiff neck and severe headache (due to meningitis), temporary paralysis of facial muscles (Bell's palsy), numbness, pain or weakness in the limbs, or poor motor coordination.
- Heart problems
  A small group of people may develop heart problems, such as irregular heartbeat, several weeks after infection.
- Other symptoms
  Less common symptoms include eye inflammation and severe fatigue.

What is Lyme disease?

Lyme disease is an infection caused by a bacterium called Borrelia burgdorferi. It is usually transmitted by the bite of an infected tick. Ticks most commonly infected with B burgdorferi usually feed and mate on deer.

Treatment

Lyme disease can be treated with antibiotics. But the earlier the treatment is started after infection, the quicker and more complete the recovery.

Prevention

The best way to avoid getting Lyme disease is to avoid deer ticks, which are most prevalent during the summer. Deer ticks are most often found in wooded areas and nearby shady grasslands, and are especially common where the two areas merge. To minimize exposure, wear long pants and long-sleeved shirts that fit tightly at the ankles and wrists. Also wear hats, tuck pants into socks, and wear closed-toe shoes. Insect repellents can also help, but some people may have allergic reactions to them. A vaccine to prevent Lyme disease is available.

Sprains and Strains

Sprains

An injury to the ligaments that surround the joint. Bruising or tearing of the ligaments may result due to twisting the joint into an unusual position.

Strains

An injury to a muscle which is usually caused by stretching the muscle. The associated symptoms should subside within a few days. Things to do for sprains and strains:

1. First 48 hours following injury, apply ice pack as much as possible.
2. Elevate the involved area.
3. Restrict the use of the area until the swelling and pain are gone. Then, gradually increase the use of the affected area.
4. Use pain medicine as needed.
5. Call the office if your child has fever, increased redness or swelling at the site, continues to have difficulty moving the affected area after 48 hours.

Water and Sun Safety

Safe Swimming

The American Academy of Pediatrics doesn't recommend swimming lessons for children under 3, since they can give both the kids and their parents a false since of security.

But it's never too soon to teach children about water safety—and the best way to do that is to set a good example. The following rules apply to all ages:

- Walk, don't run, around swimming pools or on docks.
- Never push another person into the water or hold another person under water.

- Never swim alone.
- Don't cry for help unless its an emergency.
- Never dive headfirst into water unless you know it's deep enough that you won't hit bottom. When in doubt, go feet first.
- Always use a life vest when boating, fishing, inner-tubing, or playing in a river or stream.
- Never try to swim, float, or boat over a dam. Get out, walk around the barrier, and get back into the water well below the current.
- Don't swim around boats or other watercraft with propellers, since they can cause serious injury.
- Children shouldn't use blow-up toys or mattresses unsupervised in a pool or any other body of water. These toys can make your child feel overly confident, and it can be dangerous if the toy deflates or if the child slips out of or off it.

Boating Basics

- No matter what type of boat you're on, every person aboard should wear a properly fitting life vest at all times.
- Make sure the life vest is approved by the U.S. Coast Guard. Kids under 5 should wear a vest with a flotation collar.
- Always keep straps and buckles securely fastened so that the vest can't slip over the head.
- Blow-up water wings, ring-shaped toys, rafts, and air mattresses should never be used as substitutes for life vests.

Sun Safety Tips

The AAD urges physicians to advise patients to do the following:

- Try to avoid sun exposure between 10 a.m. and 4 p.m.
- Use a sunscreen with a sun protection factor (SPF) of at least 15 and wear it year-round.
- Reapply sunscreen every 2 hours when outdoors, even on cloudy days.
- Wear a long-sleeved shirt, pants, hat with a 4-inch brim, and sunglasses.
- Stay in the shade when possible.
- Avoid reflective surfaces.
- Apply sunscreen to infants beginning at 6 months of age.
- Teach these rules to children.
- Seek medical help if a mole changes in size, shape, or appearance.

What does SPF mean?

SPF stands for sun protection factor, a U.S. Food and Drug Administration rating system. To use SPF numbers, a person must know how long it takes for his or her unprotected skin to bum.

If the skin reddens after 10 minutes of sun exposure, for example, that person while wearing an SPF 15 sunscreen, applied as thickly as the manufacturer recommends, should be able to stay in the sun 15 times longer (150 minutes) without burning, the FDA says. Swimming and perspiration reduce SPF value, however, even of water-resistant products.

The SPF rating system applies only to UV-B rays. Some products also protect against UV-A rays, but there is no system to rate UV-A protection yet. No sunscreen offers total protection. Persons with dark skin, while less likely to bum, may still develop skin damage that includes premature aging and skin cancer from sun exposure.

Cholesterol and Your Child

You've probably heard the recommendation that all adults know their level of blood cholesterol, and that adults with high levels (a major heart disease risk) lower them through dietary changes and other methods. Since heart disease tends to run in families, many parents are concerned to whether or not these recommendations apply to children as well.

Doctors still have many unanswered question on this topic. There is much to be learned about the potential for preventing heart disease from childhood on. Most experts agree, however, that it can't hurt—and will probably help—to start encouraging a healthier life-style in our youngsters. After all, heart disease is the number one cause of death in this country, and high blood cholesterol is a major contributor to it.

Why Prevention is Important

Through a process called atherosclerosis, deposits of cholesterol and other substances can build up in the arteries that supply the heart muscle, eventually blocking the flow of blood and causing angina (chest pain) or a heart attack. In the brain, this same process can cause a stroke.

Cardiovascular disease almost never causes symptoms until middle age or later, but cholesterol starts collecting inside the arteries decades earlier. Studies have shown signs of fatty deposits already forming in the coronary arteries of children and young adults. Furthermore, children with high levels ofLDL ("bad") cholesterol in the blood seem most likely to have these deposits. In general, children with high blood cholesterol tend to have high levels as adults, and their families often have higher rates of heart disease. American children have an average cholesterol of about 150 to 160 milligrams per deciliter, considerably higher than in countries like Japan, where heart disease is less common.

What About Testing?

Should your child have a blood cholesterol test? This is a decision to make in consultation with your pediatrician or family doctor. In general, a cholesterol test is most strongly recommended for children whose families have a history of early heart disease (onset before age 55) or whose parents or close relatives have high blood cholesterol levels. (A family history includes parents, grandparents, siblings, aunts, or uncles). If either parent has high blood pressure, diabetes, or is very overweight, this may be an added reason to test a child.

If your child's blood cholesterol is higher than average, don't be alarmed. This doesn't mean he or she is unhealthy or destined to be so. However, high blood cholesterol value (which should be confirmed with a second test) does make lifelong preventive measures

especially important. These measures are easier to follow if adopted early on: eating a diet moderate in saturated fat and cholesterol, getting plenty of exercise, not smoking, and maintaining and appropriate weight. The pediatrician may also wish to perform further tests to determine the relative proportion of "good" (HDL) and "bad" (LDL) cholesterol in the blood, especially if your child's total cholesterol is above 200.

About one in 500 children has an inherited defect in the body's ability to use cholesterol. This condition, called familial hypercholesterolemia, requires special attention to a low-fat diet (often with guidance from a registered dietitian) and in some cases may also call for drug therapy. The close relatives of children with this condition should have cholesterol tests themselves, if they haven't already done so. In most children with above-average blood cholesterol, however, moderate changes in diet are enough to bring cholesterol down to desired levels (150 or below).

Your Child's Diet: How Much Fat?

Even if you are very concerned about high blood cholesterol, heart disease, or obesity in your family, there is not need to impose dietary restrictions on children up to two years of age, unless specifically recommended by your pediatrician. In these first two years, children need a rich supply of calories, including fats, to support their rapid growth an development. Mother's milk, the best source of nourishment for infants, is relatively high in fat and cholesterol.

As children make the transition to table food, they can start sharing family meals that are more moderate in saturated fat and cholesterol, the two dietary components that help raise blood cholesterol. This doesn't mean cutting the amount of food or the number of calories your children eat; in fact, such restrictions deprive them of needed nutrients. All children need three full meals a day, with a balanced selection of foods from the four basic groups (meat and fish; dairy; bread and starchy vegetables; fresh fruits and vegetables). In addition, children who eat lightly or unreliably at mealtimes may need extra energy from snacks. Your child's growth should be checked regularly by the pediatrician to make sure height and weight are appropriate for age.

Instead of cutting back on foods, replace them with other nutritious choices. Saturated fat is found in whole milk products, fatty meats, and certain oils (like coconut and palm) used in many store-bought snacks and desserts. Dietary cholesterol is found only in animal products—mainly egg yolks and organ meats, but all fish, meat, poultry and dairy products as well.

There is no need to ban red meat or milk from children's diets. Red meat is an excellent source of protein, iron, and zinc; just choose lean cuts, trim visible fat, keep portion size modest, and use cooking methods that let fat drain away. Serve skinless poultry or fish as alternative hot dogs or luncheon meats. As for milk and dairy products, a vital source of calcium and other nutrients, older children can gradually switch from whole milk to 2%, 1% or skim milk. Other low-fat dietary products include shakes or puddings made with low-fat milk; low-fat yogurt or frozen yogurt pops; and low-fat cheeses, served grilled on toast or in casseroles. Her are some other suggestions for trimming fat and cholesterol in family meals:

1. Make fast food and ice cream a treat, rather than staple. Encourage the choice of plain hamburgers over those topped with cheese, bacon, or sauce; fruit juice or milk over thick shakes; salad bar instead of fried chicken or fish; and pizza with mushrooms or peppers instead of sausage or pepperoni.

2. Limit egg yolks to two per week.

3. Several times a week, replace meat with fish or complex carbohydrate combinations (like rice and beans) as a main course. Whole-grain breads, cereals, and pasta also belong to the complex carbohydrate family.

4. Keep a variety of healthy snacks on hand, such as vegetable sticks, graham crackers, oatmeal cookies, low-sugar cereal, seedless fruit, and grain, fruit, or vegetable bread or muffins.

5. For school children, review the cafeteria menu in advance and pack home-made lunches to replace high-fat selections. Good choices include sandwiches made with chicken, turkey, tuna, lean ham or beef, low-fat cheese, lettuce and tomato, preferably on whole-grain bread; peanut-butter and jelly or fruit spread sandwiches; pita bread with salad, meat or bean stuffing; leftover macaroni; individual serving packs of yogurt or applesauce; and fresh or dried fruits.

Children cooperate more readily with any effort when they feel like participants. Teach your child to read nutrition labels on food, and let him or her help with food shopping and meal preparation whenever possible.

A Family Affair

Children aren't likely to adopt habits unless they are part of the family's everyday life. Your good example is the best teacher. If parents have regular medical checkups, watching, children are apt to follow in their footsteps. (Smoking, for instance, is less common among children ofnonsmokers).

It may be years before researchers understand just how we can best protect our children against heart disease later in life. Meanwhile, it's never too early to start encouraging choices that will help reduce the risk over the course of a lifetime.

Age	Gender	Mean	95th Percentile
0-4	Boys	155	203
	Girls	156	200
5-9	Boys	160	203
	Girls	164	205
10-14	Boys	158	202
	Girls	160	201
15-19	Boys	150	197
	Girls	158	203

Toilet Training

General Guidelines

1. Long before training is begun, parents can teach readiness skills in a graduated fashion such as dressing. Children can also be taught to follow oneand two-stage directions and appropriate language about toileting. The understanding and expression of language greatly facilitates the training process.
2. Training should probably not begin before a child is 24 months of age. Children over 24 months of age are more easily and quickly trained than children under 24 months. The efforts necessary to train a younger child cancel out any potential benefit and may create unnecessary conflict.
3. Children leam much by observing and imitating their parents. Children can occasionally accompany their parents to the bathroom. Parents can use their own preferred toileting vocabulary to describe the elimination process. The child will begin to associate his own elimination process with the appropriate location for that process to occur.
4. Children should not be required to sit on the potty for extended periods of time. Five to ten minutes is sufficient. Adults do not eliminate on command and this should not be expected of children.
5. Children can be placed on the potty at times when elimination is likely to occur, such as after a meal.
6. As much as possible, the training process needs to be pleasant for both children and parents. Physical punishment definitely has no place in the training process. Punishment does not teach and the resulting negative side effects can create unnecessary parent-child conflicts. Praise for appropriate toileting can help to motivate the child.

Bed Wetting

Bed-wetting is a very common problem—so common we consider it normal until at least 6 years of age. Some 40% of 3-year-olds urinate involuntarily in their sleep, as do 10% of 6-year-olds and 3% of 12-year-olds. The medical term for this is enuresis.

Most children who urinate in their sleep have bladders that are too small to hold all the urine produced in a night (this is an inherited characteristic), and don't awaken to the signal of a full bladder. Enuresis is rarely caused by a physical disor- der, and your pediatrician can detect those few cases that are. Emotional problems do not cause enuresis, either, but mishandling of bed-wetting can create psychological difficulties for children.

Most children who wet the bed overcome the problem between 6 and 10 years of age. Even without treatment, all children eventually get over it. Therefore, treatments that might have harmful complications should not be used. Treatments without side effects, however, can be started as soon as your child has been toilet-trained for longer than six months.

Help for children of any age

- Encourage your child to get up to urinate during the night. This advice is more important than any other. Tell your child at bedtime, "Try to get up when you have to pee." Leaving a light on in the bathroom may help. Some preschoolers prefer to use a potty chair left next to the bed.
- Encourage your child to postpone urination. If your child urinates often during the day, encourage him to go less frequently, but don't make an issue of it. Don't remind him to use the bathroom except at bedtime. Your child should start his night with an empty bladder.
- Encourage fluids during the morning and early afternoon. The more fluids your child drinks, the more urine she will produce, and more urine leads to larger bladders.
- Discourage drinking more than two ounces of fluids during the two hours before bedtime. Give gentle reminders about this, but don't argue about a few swallows of water.
- Protect the bed from urine. Have your child wear extra thick underwear in addition to his pajamas. This keeps much of the urine from getting through to the sheets. By 4 years of age, your child should no longer be using diapers or plastic pants. However, special absorbent underpants are helpful for camping or ovemights at someone else's house. Protect the mattress with a plastic mattress cover. Odor becomes a problem if urine soaks into the mattress or blankets.
- Establish a morning routine for wet pajamas and wet bedding. On wet mornings, your child can rinse her pajamas and underwear in the sink until the odor is gone. If she smells of urine, she will need to take a quick shower so she won't be teased at school. You can cut down on the laundry by placing a dry towel under your child's bottom each night. This can be rinsed each morning and saved until you do your wash. If a wet bed is left open to the air, the sheets are usually dry by noon. Because of odor, the sheets may need to be washed one extra time each week.
- Respond positively to dry nights. Praise your child on mornings when he wakes up dry. A calendar with gold stars or "happy faces" for dry nights may also help.
- Respond gently to wet nights. Your child does not like being wet. Most bed-wetters feel guilty and embarrassed about this problem. They need sympathy, not blame or punishment. Punishment or pressure will delay a cure and cause secondary emotional problems. Do not allow siblings to tease a bed wetter.

Problems with Soiling and Bowel Control

Most children can control their bowels and are toilet trained by the time they are four years of age. Problems controlling bowel movements can cause soiling which leads to frustration and anger on part of the child, parents, teachers and other people important in the child's life. In addition, social difficulties with this problem can be severe - the child is often made fun of by friends and avoided by adults. These problems can cause children to feel badly about themselves. Some of the reasons for soiling are:

1. problems during toilet training.
2. physical disabilities, which make it hard for the child to clean him/herself.
3. physical illnesses, for example Hirschprung's Disease.
4. family or emotional problems.

Soiling which is not cause by an illness or disability is called encopresis.

Children with encopresis may have other problems, such as short attention span, low frustration tolerance, hyperactivity and poor coordination. Occasionally, this problem with soiling starts with a stressful change in the child's life, such as the birth of a sibling, separation/divorce of parents, family problems, or a move to a new home. Encopresis is more common in boys that in girls.

School-age children with soiling or bowel control problems should have a complete physical evaluation by a family physician or pediatrician. If no physical causes are found, or if problems continue after examination by a family physician, the next step is an evaluation by a child and adolescent psychiatrist. The child and adolescent psychiatrist will review the results of the physical evaluation and then decide whether emotional problems are contributing to the encopresis.

Child and adolescent psychiatrists treat encopresis with a combination of educational, psychological and behavioral methods. Most children with encopresis can be helped, but progress can be slow and extended treatment may be necessary. Early treatment ofasoiling or bowel control problem can help prevent and reduce social and emotional suffering and pain for the child and family.

Meal Time and Behavioral Problems

Mealtimes should not only be pleasant family times but also a time to teach your child the kind of manners and behavior that you want him to exhibit when eating. If you allow your child to misbehave during mealtimes at home, the same thing will happen when you go out or have company; "Company manners" can only be taught to your child during regular meals at home. If you consistently follow these procedures, mealtime will not be a problem, and "company manners" and "regular manners" will become one.

1. Establish reasonable rules for your child. For example: you must remain seated; food is chewed with closed mouth and swallowed, not spit out, etc. The rules will depend on the age of your child. Discuss this with your health care provider.
2. Be sure to praise all appropriate behaviors whenever they occur. You cannot praise too often. Prompt the behaviors you want. This is how you teach your child to behave at mealtime.
3. Teach your child the behaviors you want. Once he has exhibited the behaviors you can be assured he knows the rules. Any infraction of the rules after that should be considered inappropriate.
4. Be sure to include your child in the mealtime conversation. Do not carry on adult conversations for extended periods of time, as this is inviting your child to misbehave at mealtimes.

5. If your child break a rule, remove him from the table (timeout) and then have him practice the correct behavior.
6. To avoid having a timeout become a game, only use it twice for any behavior during a meal. The third time a rule is broken, the meal is over.
7. If your child continues to misbehave, remove him from the table and take away his plate regardless of how much he has eaten. This should be done matter-of-factly. There is no need to nag him about what he has done. This will not hurt your child and will not have to be done often.
8. Do not allow your child to eat or drink anything except water until the next meal.
9. Discipline whining or constantly asking for snacks by placing your child in timeout.
10. Remind your child of the rules very nicely right before the next meal and continue to use the above procedures.
11. Don't forget to praise all appropriate behaviors very frequently.
12. Set a specific time limit during which food can be eaten and after which the plate will be removed. Purchase and use a portable timer to tell you when mealtime is over.

Bed Time and Crying

1. Establish a reasonable bedtime or nap time, and under normal day to day circumstances put your child to bed at that time every time.
2. About 30 minutes prior to bedtime, start "quiet time" during which your child should engage in quiet activities rather than roughhousing, etc.
3. Go through your regular bedtime routine (bedtime story, drinks, kisses, bathroom).
4. Have your child in bed at the established time. Tell him goodnight and that you will see him in the morning, turn off the light, leave the room, and close the door (optional).
5. Do not go back into the room. Your child may cry for a very long time, but if after 1 or 2 hours you go in and pick him up, you will teach him that all he has to do is cry for a long time, then mommy will come back in. Your child may also try a variety of different noises, calls, etc., in an effort to get you to give in, but don't fall for these. Stay out of the room.
6. Don't get discouraged—it only takes a few nights.
7. After your child is regularly going to bed without crying for more than a minute or two, it is all right to check on him if he continues to cry to make sure nothing is wrong.

Follow these suggestions for any bedtime crying to avoid having the bedtime problem recur:

- Do not talk to your child after he is down for the night.
- Check diapers, etc. as quickly as possible.
- If everything is okay, leave the room without saying a word or holding your child.

Bed Time and Getting Out of Bed

1. Establish a reasonable bedtime or nap time, and under normal day to day circumstances put your child to bed at that time every time.
2. About 30 minutes prior to bedtime, start "quiet time" during which your child should engage in quiet activities rather than roughhousing, etc.
3. Go through your regular bedtime routine (bedtime story, kisses, drinks, bathroom).
4. Have your child in bed at the established time. Tell him goodnight and that you will see him in the morning, turn off the light, leave the room, and close the door (optional).
5. Monitor your child very closely the first few nights to catch him getting out of bed the instant he gets up.
6. When your child gets up, give him one spank, and put him back in bed. Make this as matter-of-fact as possible.
7. Continue doing this each time he gets up. You may be surprised how often he will get up the first night or two, but don't get discourage as he is just testing to find out whether or not you really mean it. Don't give up.
8. In the morning, verbally praise your child for staying in bed (if he does) and reward him with something such as allowing him to choose between two different favored foods for breakfast.

Typical Behavioral Sleep Problems

Problem: Habitual night feeding. (Disrupts sleep after 4 months of age in the 10% of babies who haven't learned to sleep 8 hours or more without feeding.)

Treatment:

- Gradually stretch daytime feeding intervals to 4 hours or more to eliminate the "grazing" habit.
- Feed the baby in a room other than the bedroom.
- Stop any nap time or bedtime feeding before the baby falls asleep.
- Make nighttime feedings brief and boring.
- Phase out nighttime feedings by gradually reducing the amount until the baby no longer craves food at night.

Problem: Habitual night crying. (Occurs after 4 months of age in babies who have been "trained" to rely on parents to get them to sleep.)

Treatment:

- Put the baby in the crib when he's drowsy but still awake.
- Leave him to cry it out, checking on him briefly every 15 minutes. He'll cry 30-90 minutes the first night but should sleep through the night within 2 weeks.

Problem: Bedtime refusal. (Affects children older than 2 years.)

Treatment:

- Start a pleasant bedtime ritual, then enforce a rule mai me cnnu uamiui leave the room once the ritual is completed.
- Ignore all further conversation and questions.
- Leave the bedroom door open as long as the child follows the rule, but close it (barricading it if necessary) if he or she screams or comes out.
- Reopen the door every 15 minutes to briefly remind the child that it will stay open if he follows the rule.

Problem: Nighttime wakening or early rising. (Affects children older than 2 years.)

Treatment:

- Delay bedtime and reduce naps because the child needs less sleep.
- Sternly order him back to his room if he crawls in bed with parents, escorting him if necessary.
- Set a radio alarm for an appropriate time, then enforce the rule that he cannot leave the room until the music comes on.

Making Daycare a Good Experience

Most child and adolescent psychiatrists recognize that the ideal environment for raising a small child is in the home with parents and family. Intimate daily direct parental care of infants for the first several months of life is particularly important. Since the ideal environment often is not available, the role of day care, especially in the first few years of the child's life, needs to be considered. Some experts recommend a minimum of six or more months leave for parents. All agree that when day care is used, the quantity and quality of the day care are significant in the child's development.

Before choosing a day care environment, parents should be familiar with the stat4e licensure regulations for child care. They should also check references and observe the caregivers with the child.

Parents sometimes take their young child to the home of a person who is also caring for one or more others. In this family-based day care, infants and children under 2 *Vi* need:

- More adults per child than older children require.
- A lot of individual attention.
- The same caregiver(s) over a long period.
- A caregiver who will play and talk with them, smile with them, praise them for their achievements, and enjoy them.

Parents should seek a caregiver who is self-confident, affectionate and comfortable with the children. The caregiver should be able to encourage social skills and positive behavior, and set limits on negative ones. Parents should be sensitive to the caregiver's capacity to relate to children of different ages. Some individuals can work well only with children at a specific stage of development.

It is wise for parents to find out how long the individual plans to work in this day care job. High turnover of individuals, several turnovers, or any turnover at critical points of development, can distress the child. If parents begin to think or feel the day care they have chosen is unsatisfactory, they should change caregivers.

Many children, particularly after the age of three, benefit from good group day care, where they can have fun and learn how to interact with others. Child and adolescent psychiatrists suggest that parents seek day care services with:

- Trained, experienced teachers who enjoy, understand and can lead children.
- The same day care staff for a long period of time.
- Opportunity for creative work, imaginative play and physical activity.
- Space to move indoors and out.
- Enough teachers and assistants—ideally, at least one for every five (or fewer) children.
- Lots of drawing and coloring materials and toys, as well as equipment such as swings, wagons, jungle gyms, etc.
- Small rather than large groups if possible. (Studies have shown that five children with one caregiver is better than 20 children with four caregivers.)

If the child seems afraid to go to day care, parents should introduce the new environment gradually: at first, the mother or father can go along, staying nearby while the child plays. The parent and child can stay for a longer period each day until the child wants to become part of the group.

Though parents may worry about how the child will do, they should show pleasure in helping their child succeed. If the child shows unusual or persistent terror about leaving home, parents should discuss it with their pediatrician.

Using Timeout for Behavioral Problems

Timeout involves placing your child on a chair for a short period of time following the occurrence of an unacceptable behavior. This procedure has been effective in reducing problem behaviors such as tantrums, hitting, biting, failure to follow directions, leaving the yard without permission, and others. Parents have found that timeout works better than spanking, yelling, or threatening their children. It is most appropriate for children form 18 months through 10 years.

Preparations

1. You should purchase a small portable kitchen timer.
2. A place for timeout should be selected. This could be a chair in the hallway, kitchen, or comer of a room. It needs to be a dull place (not your child's bedroom) where your child cannot view the television or play with toys. It should not be a dark, scary, or dangerous place. The aim is to remove your child to a place where not much is happening, not to make your child afraid.
3. You should discuss with your spouse which behaviors will result in timeout. Consistency is very important.

Practicing

1. Before using timeout for discipline, you should practice using it with your child at a pleasant time.
2. Tell your child there are two rules when in timeout:

Rule 1: The timer will start when he is quiet. Ask your child what would happen if he talks or makes noises when in timeout. Your child should say the timer will be reset or something similar. If he does not say this, remind him of the rule.

Rule 2: If he gets off the chair before the timer rings, you will give one hard spank and replace him in the chair. Ask your child if he wants to get off the chair and get one hard spank to learn this rule. Children usually decline this offer.

Rule 3: After explaining the rules and checking out your child's understanding of the rules, go through the steps under "C." Tell your child you are "pretending" this time.

Rule 4: Mention to your child you will be using this technique instead of spanking, yelling, or threatening. Most kids are pleased to learn this.

Procedure

Step 1: Following an inappropriate behavior, say to the child, "Oh you... (describe what the child did)." For example, "You hit your sister. Go to timeout please." Say this calmly and only once. It is important not to lose your temper or begin nagging. If your child has problems getting to the chair quickly, guide him with as little effort as needed. This can range from leading the child part way by the hand to carrying the child to the chair. If you have to carry your child to the chair, be sure to hold him facing away from you so he doesn't confuse a hug with a trip to timeout.

Step 2: When your child is on the chair and quiet, set the timer for a specific number of minutes. The rule of thumb is one minute for each year of age up to five minutes. A two year old should have two minutes; a three year old three minutes; and a five year old, five minutes. For children five years and above, five minutes is the maximum amount of time. If your child makes noises, screams, or cries, reset the timer. Do this each time the child makes any noises. If your child gets off the chair before the time is up, give him one hard spank on the bottom, replace the child on the chair, and reset the timer. Do this each time the child gets off the chair. If these procedures are followed carefully, spanking will rarely be necessary after about three days.

Step 3: After your child has been quiet and seated for the required amount of time, the timer will ring. Go to the timeout chair and ask your child if he would like to get up. Do not speak from across the room. A nod of the head or a positive or neutral answer is required. Answering in an angry tone of voice or refusing to answer is not acceptable. If your child is still mad, he will probably get into trouble again in a short period of time. Should your child answer in an angry tone or refuse to answer, reset the timer. Your child may then answer appropriately, but once the timer is reset it must go to the full amount of time. You are the one who should decide when your child gets off the timeout chair, not your child.

Step 4: As soon as your child is off the timeout chair, you should ask if he wishes to repeat the behavior which led him there in the first place. For example, "Would you like to hit your sister again so I can put you in timeout and then you will leam the rule?" Generally, children say no or shake their head. You can then say, "I'm happy you don't want to hit your sister." If your child should take you up on this offer and repeat the unacceptable behavior, calmly place him in timeout. Although this may sound like you are daring your child to misbehave, it is better if he repeats the behavior in your presence. That way, your child will have several opportunities to leam that unacceptable behaviors result in timeout.

Step 5: After your child finishes a timeout period, he should start with a "clean slate." It is not necessary to discuss, remind, or nag about what the child did wrong. Within five minutes after timeout, look for and praise good behavior. It would be wise to take your child to a different part of the house and start him in a new activity. Remember, catch 'em being good.

Summary of the Rule For Parent:

- Decide about behaviors you will use timeout for ahead of time. Discuss these with your child.
- Don't leave your child in timeout and forget about him.
- Don't nag, scold, or talk to your child when he is in timeout. All family members should follow this rule!
- Remain calm, particularly when your child is being testy.

For Children:

- Go immediately to timeout when you're asked to. Don't argue.
- Remain quiet and stay on the timeout chair until you're asked to get down. You'll spend less time that way.
- The timer is not to be touched by any child in the house. If you do touch it, you will be placed in timeout.

Brothers and Sisters:

- If you tease, laugh at, or talk with your brother or sister while they are in timeout, you will be placed on the chair and your brother or sister will get down.

When Timeout Does Not Work

1. Be sure you are not warning your child one (or more) times before sending him or her to the timeout chair. Warnings only teach your child that he or she can misbehave at least once (or more) before you'll use timeout.
2. All adults who are responsible for disciplining your child at home should be using the timeout chair. You should agree when and for what behaviors to send your child to timeout. (You will want new sitters, visiting friends, and relatives to read and discuss the timeout guidelines.)
3. In order to maximize the effectiveness of timeout, you must make the rest of the day ("time-in") pleasant for your child. Remember to let your child know when he or she is well-behaved ("Catch'em being good") rather than taking good behavior for granted. Most children would prefer to have you put them in timeout than ignore them completely.
4. Your child may say "Going to the chair doesn't bother me," or "I like time out." Don't fall for this trick. Many children try to convince their parents that timeout is fun and therefore not working. You should notice over time that the problem behaviors for which you use timeout occur less often. (Timeout is not supposed to be a miserable experience.)
5. When you first begin using timeout, your child may act like timeout is a "game." He or she may put himself or herself in timeout or ask to go to timeout. If this happens, give your child what he or she wants-that, put him or her in the timeout and require your child to sit quietly for the required amount of time. Your child will soon leam that timeout is not a game. Your child may also laugh or giggle when being placed in timeout or while in timeout. Although this may aggravate you, it is important for you to completely ignore your child when he or she is in timeout.
6. You may feel the need to punish your child for doing something inappropriate in the chair (such as cursing or spitting). However, it is very important to ignore your child when he or she behaves badly in timeout. This will teach your child that such "attention-getting" strategies will not work. If your child curses when out of the chair (and it bothers you), be sure to put the child in timeout.

7. Television, radio, or a nice view out the window can make timeout more tolerable and prolong the length of time your child must stay in the chair by encouraging him or her to talk. Try to minimize such distractions.

8. You must use timeout for major as well as minor behavioral problems. Parents have a tendency to feel that timeout is not enough of a punishment for big things and thereby discipline inconsistently. Consistency is most important for timeout to work for big and small problems.

9. Be certain that your child is aware of the rules, that if broken, result in timeout. Frequently, parents will establish a new rule (e.g., "Don't touch the new stereo") without telling their children. When their children break the rule, they don't understand why they are being put in timeout.

10. Review the timeout guidelines to make certain you are following the recommendations. If your child is getting off the chair frequently, be sure to give one swat on the bottom and place your child back on the chair without talking.

11. When your child is in timeout:

    - Don't look at him or her.
    - Don't talk to him or her.

Discipline

Helping a child to behave in an acceptable manner is a necessary part of raising the child well. Discipline varies at different ages. There is no one right way to raise children, but child and adolescent psychiatrists offer the following general guidelines: Children generally want to please their parents. Wise parents can in their disciplining activities use children's desire to please.

When parents show joy and approval for behavior that please them, this reinforces good behavior in the child. When parents show disapproval of dangerous or unpleasant behaviors at the early stages, they are more likely to be successful when the child is older. The way the parent corrects a child or adolescent for misbehavior should make sense to the youngster, and not be too strict that the child or adolescent cannot later feel the parent's love and good intentions.

Children and adolescents can and do anger parents, and parents need good self-control when they are angry. Although a loud "no" may get the attention of a toddler heading for a street full of traffic, it does not quiet a crying baby. For older children, there should be clear expectations, agreed upon by both parents and clearly told to the child or adolescent. In our mixed society, where cultures and parenting styles are varied, different families expect different behaviors from their children.

One child may be allowed to come home at any time, while another child may have a strict curfew. When parents and children disagree about rules, an honest exchange of ideas may help them leam from each other. However, parents must be re- sponsible for setting the family's rules and values. Keeping unwanted behavior from happening in the first place is easier than stopping it later.

It is better to put breakable or treasured objects out of the reach of toddlers than to punish them for breaking them. Parents should encourage curiosity but should direct it into activities like playing with puzzles, learning to use paints or reading a book. Changing a child's unwanted behaviors can help the child have the self-control needed to become responsible and considerate of others. Self-control does not happen automatically or suddenly. Infants and toddlers need parental guidance and support to begin the process of learning self-control. Self-control usually begins to show by age six. With parents guiding the process, self-control increases throughout the school years. Teenage experimentation and rebellion may occur but most youngsters pass through this period and become responsible adults—especially if they had good early training. Families pass methods of discipline and what is expected of children from generation to generation.

When discipline attempts are not successful, it is often helpful for someone outside the family to make useful suggestions on raising a child. Professionals trained in child growth and behavior can give information on the way children think and develop. They can also suggest different approaches to changing unwanted behavior. The patience of parents, and help from caring professionals, when necessary, will help smooth the way for children to leam and enjoy what society expects of them and what they can expect from themselves.

Conduct Disorders

"Conduct disorders" are a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill.

Their expression of anger is the major problem. They are often aggressive, both physically and verbally, with other children and to adults. They may lie, steal, destroy property and misbehave sexually.

Research shows that the future of these youngsters is likely to be very unhappy if they and their families do not receive early, ongoing and comprehensive treatment.

Without treatment, many youngsters with conduct disorders are unable to adapt to the demands of adulthood and continue to have problems with relationships and hold a job. They often break laws or behave antisocially. Many children with a conduct disorder may be diagnosed as also having a coexisting depression or an attention deficit disorder.

Many factors may lead to a child developing conduct disorders, including brain damage, child abuse, defects in growth, school failure and negative family and social experiences. The child's "bad" behavior causes a negative reaction from others, which makes the child behave even worse.

Treatment of children with conduct disorders is difficult because the causes of the illness are complex and each youngster is unique. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. A child and adolescent psychiatrist uses information from other medical specialists, and from the child, family and teachers to understand the causes of the disorder and then organize a comprehensive treatment plan.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Remedial education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention and controlling movement or those having an associated depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, treatment offers a good chance for considerable improvement in the present and hope for a more successful future.

Children and Lying

Honesty and dishonesty are learned in the home. Parents are often concerned when their child or adolescent lies.

Lying that is probably not a serious problem:

Young children (ages 4-5) often make up stories and tell tall tales. This is normal activity because they enjoy hearing stories and making up stories for fun.

These young children may blur the distinction between reality and fantasy.

An older child or adolescent may tell a lie to be self-serving (e.g. avoid doing something or deny responsibility for their actions). Parents should respond to isolated instances of lying by talking with the youngster about the importance of truthfulness, honesty and trust.

Some adolescents discover that lying may be considered acceptable in certain situations such as not telling a boyfriend or girlfriend the real reasons for breaking up because they don't want to hurt their feelings. Other adolescents may lie to protect their privacy or to help them feel psychologically separate and independent from their parents (e.g. denying they sneaked out late at night with friends).

Lying that may indicate emotional problems:

Some children, who know the difference between truthfulness and lying, tell elaborate stories which appear believable. Children or adolescents usually relate these stories with enthusiasm because they receive a lot of attention as they tell the lie.

Other children or adolescents, who otherwise seem responsible, fall into a pattern of repetitive lying. They often feel that lying is the easiest way to deal with the demands of parents, teachers and friends. These children are usually not trying to be bad or malicious but the repetitive pattern of lying becomes a bad habit.

There are also some children and adolescents who are not bothered by lying or taking advantage of others. Other adolescents may frequently use lying to cover up another serious problem. For example, an adolescent with a serious drug or alcohol problem will lie repeatedly to hide the truth about where they have been, who they were with, what they were doing, and where the money went.

What to do if a Child or Adolescent lies:

Parents are the most important role models for their children. When a child or adolescent lies, parents should take some time to have a serious talk and discuss:

- The difference between make believe and reality, lying and telling the truth.
- The importance of honesty at home and in the community.
- Alternatives to lying.

If a child or adolescent develops a pattern of lying which is serious and repetitive, then professional help may be indicated. Evaluation by a child and adolescent psychiatrist would help the child and parents understand the lying behavior and would also provide recommendations for the future.

Children Who Won't Go to School

Going to school usually is an exciting, enjoyable event for young children. For some it brings fear or panic. Parents have cause for concern when their child regularly feels sick from tension, "plays sick" or with minor physical complaints wishes to stay home from school. Often the child five to ten years of age who behaves this way is suffering from a paralyzing fear of leaving the safety of parents and home. The child's panic is very difficult for parents to cope with, but these fears can be treated successfully, with professional help.

The first appearance of unreasonable fear of school is typically in nursery school, kindergarten or first grade, and it peaks in second grade. The child may complain of a headache, sore throat, or stomach-ache shortly before it is time to leave for school. The "illness" subsides after the child is allowed to stay home, only to reappear the next morning before school. In some cases the child may simply refuse to leave the house.

Refusal to go to school often begins following a period at home which the child has become closer to the mother, such as a summer vacation, a holiday break or a brief illness. It also may follow a stressful occurrence, such as the death of a pet or relative, a change in schools or a move to a new neighborhood.

Children with an unreasonable fear of school may feel unsafe staying in a room by themselves and may display clinging behavior, shadowing the mother or father around the house. Such fears are common among children with separation Anxiety Disorder. They often have difficulty going to sleep, and they may show exaggerated, unrealistic fears of animals, monsters, burglars or being alone in the dark. The potential long-term effects are serious for a child who has persistent fears and does not receive professional assistance. The child may develop serious for a child who has persistent fears and does not receive professional assistance. The child may develop serious educational or social problems if away from school and friends for an extended period.

The parents and child can benefit from seeing a child and adolescent psychiatrist, who will work with them in an effort immediately to return the child to school and other important daily activities. Since the panic comes from leaving home rather than being in school, frequently the child is calm once in school.

For some children, the more fundamental causes of fears will need to be treated at greater length. Refusal to go to school in the older child or adolescent is generally a more serious illness, and often requires more intensive treatment.

In any case, unreasonable fears about leaving the home and parents can be successfully treated, and parents should not hesitate to seek professional help. The child's physician can refer the parents to a child and adolescent psychiatrist.

Children Who Steal

When a child or teenager steals, parents are naturally concerned. They worry about what caused their child to steal, and they wonder whether their son or daughter is a "juvenile delinquent."

It is normal for a very young child to take something which excites interest. This cannot be regarded as stealing until the youngster is old enough—usually three to five—to understand that something belongs to a particular person. Parents should actively teach their children about property rights and the consideration of others.

Although they have learned that theft is wrong, older children or teenagers steal for various reasons. A youngster may steal to make things equal if a brother or sister seems to be favored with affection or gifts. Sometimes, a child may steal as a show of bravery to friends, or to give presents and become more popular at school.

Parents should consider whether the child has stolen out of a need for more attention. In such cases, the child may be expressing anger or trying to "get even" with the parents; the stolen object may become a substitute for affection. The parents should make an effort to give more recognition to the child as an important family member.

If parents take the proper measures, in most cases the stealing stops as the child grows older. Child and adolescent psychiatrists recommend that when parents find out their child has stolen, they:

- Tell the child that stealing is wrong.
- Help the youngster to pay for or return the stolen object.
- Make sure that the child does not benefit from the theft under any circumstances.
- Avoid lecturing, predicting future bad behavior or saying that they now consider the child to be a thief.
- Make clear that this behavior is totally unacceptable within the family tradition and the community.

When the child has paid for or returned the stolen merchandise the matter should not be brought up again by the parents, so that the child can begin again with a "clean slate."

If stealing is persistent and thefts continue despite these measures, the stealing probably results from more serious problems in the child's emotional development.

Children who repeatedly steal have difficulty trusting others and forming close relationships. Rather than feeling guilty, they blame the behavior on others, with the argument that, "Since they refuse to give me what I need, I will take it" Some children steal out of a fear of dependency; they wish not to depend on anyone, so they take what they need.

In treating a child who steals persistently, a child and adolescent psychiatrist will diagnose the underlying reasons for the need to steal, and plan a program of treatment. Important aspects of treatment are helping the child leam to establish trusting relationships and helping the family support the child in changing to a more healthy path of development.

The Essential Vaccines

Childhood Vaccinations

Today, few young parents remember the polio epidemic that raged into the 1950's. That's a mixed blessing. While it's good that polio is a rarity in the United States, there is always the danger of taking too lightly the need for continuing vaccinations. The same is true for the other major vaccines that have done so much to keep our children free of serious disease.

Unfortunately, the percentage of American children who have received all their recommended immunizations has actually decline during the 1980's. As a result, at least one of the diseases preventable by vaccine, whooping cough (pertussis), has been on the rise.

You may have read disturbing reports about children harmed by certain vaccines. What these reports don't always make clear is how rare such injuries are. Any risks posed by vaccines are far outweighed by the risks your child could face from the diseases vaccines prevent.

The Essential Vaccines

The major vaccines your child should receive, starting at two months of age or possibly even earlier, include:

Polio

The types of vaccine protect against this potentially crippling, even fatal, disease. Injected polio virus (IPV), which contained killed virus, is required now.

Diphtheria, Tetanus, and Pertussis **(DTaP)**

This combination shot protects against three very serious diseases. Diphtheria infects the nose and throat and then can spread to the heart and nervous system, causing permanent, potentially lethal, damage. Tetanus (lockjaw), usually caught from puncture wounds, can cause convulsions and paralysis that are fatal about half the time. Pertussis (whooping cough) leads to coughing so uncontrollable it can interfere with breathing and may cause brain damage from lack of oxygen.

Like polio vaccinations, DTP immunizations must be given a number of times from infancy through preschool. In addition, tetanus and diphtheria immunizations need to be repeated every decade throughout life.

A small number of children may be at risk for side effects from the pertussis vaccine; for them, the doctor may decide to give diphtheria and tetanus immunizations alone.

Measles, Mumps, and Rubella **(MMR)**

You may think of measles and mumps as annoying but harmless childhood diseases. However, they can both occasionally have serious, permanent side effects. Measles is still a major killer outside the United States, with occasional serious outbreaks here as well. Rubella (German measles) seldom harms the child who catches it, but if passed to a pregnant woman, it could cause severe birth defects in her baby.

Like DTP, the vaccines against these diseases are usually given in a combination shot. The American Academy of Pediatrics has recently recommended a booster shot for measles in the upper elementary grades. Check with your doctor for information regarding this shot.

In areas with continuing outbreaks of measles, vaccination may be recommended at nine months and again at 15 months. Revaccination may also be advised for anyone vaccinated when less than a year old.

Haemophilus Influenzae b **(Hib or H flu)**

This is the newest of the standard childhood vaccines. The bacterium it helps protect against is a major cause of bacterial encephalitis and meningitis, both of which can kill or cause permanent brain damage.

A Word About Risks

The most common side effects of vaccines are generally harmless and temporary; they can include redness or swelling at the injection site or a fever. More serious side effects are less common, and a very small percentage of these may cause permanent harm or death.

Pertussis vaccine (the "P" in DTaP) has cause the greatest number of side effects— but even here, major injuries have been vary rare. One study estimates that pertussis vaccine will cause brain damage in one of every 310,000 doses given. However, the risk of brain damage from pertussis itself is about one in ten. Other vaccines pose even smaller risks than the pertussis vaccine.

Still, health officials expect about 50 to 75 instances of permanent injury or death caused by childhood vaccinations each year. The National Childhood Vaccine Compensation Act, which went into effect in 1988, sets up a trust fund to compensate families hurt by childhood vaccinations.

As rare as vaccine risks are, you and your doctor should discuss precautions in any of these situations:

- **Illness with fever**: Your doctor may want to reschedule immunization for when your child recovers. Minor illness like a cold is usually not a concern.
- **Weakened immune system**: No live-virus vaccines (oral polio, measles, mumps, rubella) should be given if your child has a disease that weakens the immune system. Immune-suppressing medications, such as chemotherapy, may also make it necessary to avoid or postpone these vaccines.
- **Nervous system disorders**: Serious, worsening epilepsy or other brain disorders may be reason to avoid pertussis vaccinations.
- **Major symptoms after a previous pertussis vaccination**: Convulsions, crying spells longer than three hours, and very high fever (105 degrees and above) and a DTaP shot may be reasons to halt further pertussis vaccinations.

- **Close relatives not immunized against polio or with weakened immune systems**: This may affect the decision of which polio vaccine to use, and the doctor may advise vaccinations for the relative.

Development Checklist

At 3 months I should be able to:

- look at objects & follow them as they move
- raise my head while on my tummy
- recognize the bottle or breast

At 6 months I should be able to:

- roll over (both ways)
- babble and coo
- sit with minimum support
- turn toward normal sounds

At 12 months I should be able to:

- finger feed myself
- crawl on my hands and knees
- pull myself to a standing position
- imitate gestures (wave bye-bye)

At 18 to 24 months I should be able to:

- point to at least 5 body parts
- walk well without help
- stack 2-3 blocks
- scribble with a crayon
- say "Mama" and "Dada"

At 36 months I should be able to:

- kick a ball
- dress myself with little help
- walk up steps, alternating feet
- use 3-5 word sentences
- use a fork and spoon properly
- sort 1-3 colors and shapes

Normality

Parents are naturally concerned about the health and welfare of their children. Many parents correctly and comfortably see their youngster as normal. However, some other parents worry whether their infant, child or teenager has a problem. These worries may be about various things, for example:

- How the child is developing;
- The emotional well-being of the child;
- What the child says and thinks; and
- How the child acts—for example, eating and sleeping patterns, behavior at school and getting along with family and friends.

Child and adolescent psychiatrists can help parents and families sort out whether their child is normal. They usually examine the child and ask the parents about the child's previous health and behavior. They may also ask about how the family gets along together. It is likely that infants, children and teenagers are normal when, at the appropriate age, they enjoy their:

- Learning, school and/or work;
- Relationships within the family;
- Relationships with friends; and
- Play.

Many parents first discuss their concerns about their child's normality with a family member or friend, or with the child's personal physician, school counselor or member of the clergy—who may then refer the family to a child and adolescent psychiatrist. He or she listens carefully to the parents and child and sorts out:

- The long-term factors that tent to lead to—or protect against—a child's developing problems;
- The short-term factors that set off the child's problem;
- The factors causing these problems to persist;
- The roles of other medical conditions; and
- The combinations of school learning with social and emotional growth. Based on the evaluation, the child and adolescent psychiatrist may:
- Reassure the parents, explaining how they can enhance normal development and be more effective in parenting;
- Suggest activity or an educational program for the child, and/or education for parents, which will support normal developmental processes;
- Provide or arrange for brief counseling to help the child and parents with minor developmental problems, stressful life situations or difficulties of the child's temperament.

If the evaluation reveals a psychiatric illness, the child and adolescent psychiatrist will recommend a specific treatment program.

Parents, better than anyone else, know their child and know what is usual behavior for their child. If there appears to be a problem, seeking professional help may be difficult, but is very important. It is the first step in knowing for sure whether there is a problem, and if so, what measures will best help the child.

Children with Special Situations

Children of Parents With Mental Illness

Mental illnesses in parents represent a risk for children in the family. These children have a higher risk for developing mental illnesses than other children. The risk is particularly strong when the parent's illness is manic-depressive illness, schizophrenia, alcoholism, or other drug abuse or major depression. When both parents are mentally ill, the chance is even greater that the child might become mentally ill.

Risk can be inherited from parents, through the genes. Some of the risk also comes from parents' behavior or moods. Mental disorders can keep parents from providing the love and guidance necessary for a child's healthy development. An inconsistent, unpredictable family environment contributes to psychiatric illness in children. Mental illness can hurt the marriage and the parenting abilities of the couple, which in turn hurts the child.

Some protective or positive things can decrease the risk to children, including:

- Children knowing their parents are ill and that the children are not to blame.
- A stable home environment.
- A sense of being loved by the ill parent.
- A naturally stable and happy personality in the child.
- Inner strength and good coping skills in the child. • A strong relationship with a healthy adult.
- Friends.
- Interest in and success at school.
- Other outside interests for the child.
- Help from outside the family to improve the family environment (for example, marital psychotherapy, or a class in parenting).

Medical, mental health or social service professionals working with mentally ill adults need to inquire about the children and adolescents, especially about their mental health and emotional development. It is often useful for such youngsters to be referred to a child and adolescent psychiatrist for an evaluation.

Individual or family psychiatric treatment can help a child toward healthy development despite the problem of the parental psychiatric illness. The child and adolescent psychiatrist can help the family work with the positive elements in the home and the natural strengths of the child. With treatment, the family can leam ways to lessen the effects of the parent's mental illness on the child.

Unfortunately, families, professionals and society often pay most attention to the mentally ill parent, and ignore the children in the family. Providing more attention and support to the children of a psychiatrically ill parent is an important way to help prevent mental illnesses from passing from one generation to the next.

Children and Family Moves

Moving to a new community may be one of the most stress-producing experiences a family faces. Frequent moves or even a single move can be especially hard on a youngster, and this stress occurs even when there are siblings.

Moves interrupt friendships. To a new child at school, it may at first seem that everyone else has a best friend or is securely involved in a clique. The child must get used to a different curriculum, and finds him or herself ahead on certain subjects and behind on others, causing boredom and anxiety.

Children in kindergarten or first grade may be particularly vulnerable to a family move because developmentally they are just in the process of separating from their parents and adjusting to new authority figures and peer groups. The relocation can interfere with that normal process of separation by causing them to return to a more dependent relationship with their parents.

In general, the older the child, the more difficulty he or she will have with the move because of the increasing importance of the peer group. Pre-teens and teenagers may repeatedly protest the move, or ask to stay in their hometown with a friend's family. Some youngsters may not talk about their distress, so parents should be aware of the warning signs of depression, including changes in appetite, withdrawal, a drop in grades, irritability, sleep disturbances or other dramatic changes in behavior.

Children who seem depressed by a move may be reacting less to the relocation than to the stress of their parents settling in to a new area. Sometimes one parent may be against the move, and children will sense and react to this parental discord. If the child shows persistent signs of depression or distress, parents can ask their family doctor, their pediatrician or the local medical society to refer them to a child and adolescent psychiatrist, who can diagnose and treat physical as well as emotional problems that may affect children as a result of stress. The child and adolescent psychiatrist can also help parents leam how to make the new experience easier on the entire family.

To make the move easier on children, parents may take these steps:

- Explain clearly to the children why the move is necessary.
- Familiarize the children as much as possible with the new area with maps, photographs or the daily newspaper.
- Describe advantages of the new location that the child might appreciate such as a lake, mountain or an amusement park.
- After the move, get involved with the children in activities of the local church or synagogue, PTA, scouts, YMCA, etc.

- If a son or daughter is a senior in high school, consider the possibility of letting him or her stay with a trusted family until the school year is over.

The more frequently a family moves, the more important is the need for internal stability. With the proper attention from parents and professional help if necessary, moving can be a positive growth experience for children, leading to increased self-confidence and interpersonal skills.

Children and Divorce

Frequently parents who are getting a divorce are worried about the effect on their children. The parents may be preoccupied with their own problems but still realize that they are the most important people in their children's lives.

While parents may be devastated or relieved by the divorce, children are invariably frightened and confused by the threat to their security. Some parents feel so hurt or overwhelmed by the divorce that they may turn to the child for comfort or direction. Divorce can be misinterpreted by children unless parents tell them what is happening, how they are involved and not involved and what will happen to them.

Children often believe they have caused the conflict between their mother and father. Many children assume the responsibility for bringing their parents back together, sometimes by sacrificing themselves. Vulnerability to both physical and mental illnesses can originate in the traumatic loss of one or both parents through divorce. With care and attention, however, a family's strengths can be mobilized during a divorce, and children can be helped to deal constructively with the resolution of parental conflict.

Parents should be aware if there are signs of persistent stress in their child or children. These may include loss of motivation for school, or for making friends or even for having fun. Other warning signs include sleeping too much or too little, or being unusually rebellious and argumentative within the family.

Children need to know that their mother and father will still be their parents even though the marriage is ending and the parents won't live together. Long custody disputes or pressure on a child to "choose sides" can be particularly harmful for the youngster and can add to the damage of the divorce.

Parents' ongoing commitment to the child's well-being is vital. If a child shows signs of stress, the family doctor or pediatrician can refer the parents to a child and adolescent psychiatrist. He or she can evaluate and treat the symptoms caused by stress. In addition, the child and adolescent psychiatrist can meet with the parents to help them leam how to make the strain of the divorce easier on the entire family.

The Autistic Child

When an infant or toddler does not cuddle, make eye contact or respond to affection and touching, parents are seriously concerned. This lack ofresponsiveness may be accompanied by an inability to communicate, and by a persistent failure to develop two-way social relationships in any situation. Many autistic children fail to show a preference for parents over other adults and do not develop friendships with other children.
The language skills may be poor, even nonexistent. Language skills as well as facial expressions and gestures are not used in a communicative manner. When a child shows these symptoms, "infantile autism" is one of the diagnoses that the child and adolescent psychiatrist will consider.

The autistic child's relationship to objects is not normal. The child may show unusual, extreme responses to objects—either avoidance or preoccupation. For example, the autistic child whose bed is moved from one side of the room to another may scream. Moving objects such as a fan hold great fascination, and the child may form an unusual attachment to odd objects such as a paper, rubber band or brick.

Another feature of autism in their child should ask their family doctor or pediatrician to refer them to a child and adolescent psychiatrist, who can accurately diagnose the autism and the degree of severity, and determine the appropriate educational measures. Autism is a disease; autistic children may have a serious lifelong disability. However, with appropriate treatment and training, some autistic children can develop certain aspects of independence in their lives. Parents should support their autistic children in developing those skills that use their strengths so they will feel good about themselves.

In addition to working with the autistic child, the child and adolescent psychiatrist can help the family resolve stress—for example, a feeling among the siblings that they are being neglected in favor of the autistic child, or embarrassment about bringing their friends home. The child and adolescent psychiatrist can help parents with the emotional problems that may arise as a result of living with an autistic child and also help them provide the best possible nurturing and learning environment for the child.

The Anxious Child

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 7 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, (such as fear of the dark, storms, animals or strangers). However, when anxieties become severe and begin to interfere with the daily activities of childhood, such as separating from parents, attending school and making friends, parents should consider seeking the evaluation and advice of a child and adolescent psychiatrist. A child or adolescent with severe separation anxiety may show some of the following:

- constant thought and fears about safety of self and parents,
- refusing to go to school,
- frequent stomachaches and other physical complaints,
- extreme worries about sleeping away from home,
- overly clingy behavior at home,
- panic or tantrums at times of separation from parents.

Some anxious children are afraid to meet or talk to new people. Children with this difficulty may have few friends outside the family. Other children with severe anxiety may have:

- many worries about things before they happen,
- constant worries or concern about school, friends or sports.

Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed.

Parents should be alert to the signs of severe anxiety so they can intervene early

to prevent complications. Early treatment can prevent future difficulties, such as, loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Severe anxiety problems in children can be treated. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

The Adopted Child

Parents with an adopted child wonder whether, when and how to tell their child that he or she is adopted. They also want to know if there are special problems for an adopted child.

Child and adolescent psychiatrists recommend that the child be told about the adoption by the adoptive parents. Children should be told about their adoption in a way that they can understand.

There are two different views on when a child should be told about the adoption. Many experts believe the child should be told at the earliest age possible. This approach provides the child an early opportunity to accept and integrate the concept of being "adopted." Other experts believe that telling a child too early may confuse the young child who can't really understand the event. These experts advise waiting until the child is older.

In either case, children should leam of their adoption from the adoptive parents. This helps give the message that adoption is good and that the child can trust the parents. If the child first learns about the adoption intentionally or accidentally from someone other than parents, the child may feel anger and mistrust towards the parents, and may view the adoption as bad or shameful because it was kept a secret. Adopted children will want to talk about their adoption and parents should encourage this process. Several excellent children's story books are available in bookstores which help parents tell the child about being adopted.

Children have a variety of responses to the knowledge that they are adopted. Their feeling and responses depend on their age and level of maturity. The child may deny the adoption or create fantasies about it. Frequently, adopted children hold onto beliefs that they were given away for being bad or may believe that they were kidnapped. If the parents talk openly about the adoption and present it in a positive manner, these worries are less likely to develop.

All adolescents go through a stage of struggling with their identity—wondering how they fit with their family, their peers, and the rest of the world, The adopted adolescent is likely to have an increased interest in his or her birth parents during this stage. This open curiosity is not unusual and does not mean that he or she is rejecting the adoptive parents. Some adolescents may wish to leam the identity of their birth parents. Adoptive parents can respond by letting the adolescent know it is okay to have this wish. The adolescent who asks should usually be given, with fact and supportive discussion, information about the birth family.

The adopted child may develop emotional or behavioral problems. The problems may or may not result from insecurities or issues related to being adopted. If parents are concerned they should seek professional assistance. A child and adolescent psychiatrist can help the child and adoptive parents determine whether or not help is needed.

Children Who Cannot Pay Attention

Parents are distressed to receive a note from school saying that their child "won't listen to the teacher" or "causes trouble in class." One reason for this kind of behavior his Attention-Deficit Hyperactivity Disorder (ADHD).

Even though the child with ADHD often wants to be a good student, the impulsive behavior and inability to pay proper attention in class interfere. Teachers, parents and friends know that the child is "misbehaving" or "different," but they might not be able to tell exactly what is wrong. A child and adolescent psychiatrist can diagnose and treat the child with Attention-Deficit Hyperactivity Disorder.

The "hyperactivity" symptoms in ADHD may include excessive running or climbing in young children, or extremely restless and fidgety behavior in older children. In contrast to a normal high level of activity in some children, hyperactivity is haphazard, poorly organized and not goal-directed. ADHD is ten times more common in boys than girls.

A child who has ADHD shows several of the following characteristics:

- Has difficulty organizing work and gives the impression he or she has not heard instructions.
- Is easily distracted.
- Makes careless, impulsive errors.
- Frequently calls out in class.
- Has difficulty awaiting his or her turn in group situations.
- Fails to follow through on parents' requests.
- Is unable to play games for the same amount of time as other children of the same age.

Without proper treatment, the child may fall behind in schoolwork, and friendships may suffer because of poor cooperation in playing and other social activities. Self-esteem suffers because the child experiences more failure than success and is criticized by teachers and family who do not recognize a health problem.

Research clearly documents that medication can be helpful, and that medication prescribed for ADHD works best as part of a comprehensive plan of treatment including ongoing evaluation and, often, medical psychotherapy for the child, help for the family, and consultation with teachers.

If a child shows behavior problems like those of ADHD, parents may ask their pediatrician or family physician to refer them to a child and adolescent psychiatrist, who can diagnose and treat the child for this illness. By meeting with the child and adolescent psychiatrist, parents can learn how to cope with their child's problem. In addition, the child psychiatrist often helps teachers and school officials work out ways to teach more effectively to those children with Attention-Deficit Hyperactivity Disorder.

Children Who Are Mentally Retarded

The term "mental retardation" is often misunderstood and seen as derogatory. Some think that retardation is diagnosed only on the basis of below-normal intelligence (IQ),

and that retarded persons are unable to learn or to care for themselves. Actually, in order to be diagnosed as mentally retarded, the person has to have both significantly low IQ and considerable problems in adapting to everyday life. However, most children who are retarded can leam a great deal, and as adults can lead at least partially independent lives. Most importantly, they can enjoy their lives just as everyone else.

In the past, parents were usually advised to institutionalize a significantly retarded child. This is not done anymore. Now these children are expected to stay in the family and take part in community life. The law guarantees them education and other services at public expense.

Retardation may be complicated by physical and emotional problems. The child may also have difficulty with hearing, sight or speech. All these problems can lower the child's potential.

It is very important that the child has a comprehensive evaluation to find out about his or her difficulties as well as strengths. Since no specialist has all the necessary skills, many professionals might be involved. General medical tests as well as tests in areas such as neurology (the nervous system), psychology, psychiatry, special education, hearing, speech and vision, and physical therapy are useful. A pediatrician or a child and adolescent psychiatrist often coordinate these tests. These physicians refer the child for the necessary tests and consultations, put together the results, and jointly with the family and the school develop a comprehensive treatment and education plan.

Emotional and behavioral disorders are a frequent complication of mental retardation, and they may interfere with the child's progress. Most retarded children recognize that they are behind others of their own age. Some may become frustrated, withdrawn or anxious, or act "bad" to get the attention of other youngsters and adults. Retarded adolescents and young adults may become depressed. These persons might not have enough language skills to talk about their feelings, and their depression may be show by new problems, for instance in their behavior, eating and sleeping.

Early diagnosis of psychiatric disorders in retarded youngsters may lead to early treatment. Contrary to common belief, medications are not the only means of treating persons who are retarded, and most of them can benefit from other psychiatric treatment as well.

A periodic child psychiatric consultation may help the family in setting appropriate expectations, limits, opportunities to succeed and other measures which will help their retarded child to handle the stresses of growing up into a fulfilled person.

Child Sexual Abuse

Child sexual abuse has been reported up to 80,000 times a year, but the number ofunreported instances is fart greater, because the children are afraid to tell anyone what has happened, and the legal procedure for validating an episode is difficult. The problem should be identified, the abuse stopped, and the child should receive professional help. The long-term emotional and psychological damage can be devastating.

Child sexual abuse can take place within the family, by a parent, step-parent, sibling or other relative; or outside the home, for example, by a friend, neighbor, child care person, teacher or random molester. However, when the sexual abuse has occurred, the child develops a variety of distressing feelings and thoughts.

No child is psychologically prepared to cope with repeated sexual stimulation. Even a two or three year old, who cannot know the sexual activity is "wrong," will develop problems resulting from the inability to cope with the over stimulation.

The child of five or older who knows and cares for the abuser becomes trapped between affection or loyalty for the person, and the sense that the sexual activities are terrible wrong. If the child tries to break away from the sexual relationship, the abuser may threaten the child with violence or loss of love. When sexual abuse oc- curs within the family, the child may fear the anger, jealousy or shame of other family members, or be afraid the family will break up if the secret is told.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling ofworthlessness and an abnormal perspective on sexuality. The child may become withdrawn and mistrustful of adults, and can become suicidal. Some children who have been sexually abused have difficulty relating to others except on sexual terms.

Some sexually abused children become child abusers or prostitutes, or have other serious problems when they reach adulthood. Often there are no physical signs of child abuse, or signs that only a physician can detect, such as changes in the genital or anal area.

The behavior of sexually abused children may include:

- Unusual interest in or avoidance of all things of a sexual nature.
- Sleep problems, nightmares.
- Depression or withdrawal from friends or family.
- Seductiveness.
- Statements that their bodies are dirty or damaged, or fear that there is something wrong with them in the genital area.
- Refusal to go to school, delinquency.
- Secretiveness.
- Aspects of sexual molestation in drawings, games, fantasies.
- Unusual aggressiveness.
- Suicidal behavior.
- Other severe behavior changes.

Child sexual abusers can make the child extremely fearful or telling, and only when a special effort has helped the child to feel safe, can the child talk freely. If a child says that he or she has been molested, parents should stress that what happened was not the fault of the child. Parents should seek a medical examination and psychiatric consultation.

These are some preventive measures that parents can take:

- Tell children that "if someone tries to touch your body and do things that make you feel funny, say NO to that person and tell me right away."
- Teach children that respect does not mean blind obedience to adults and to authority—for example, don't tell children to "Always do everything the teacher or baby-sitter tell you to do."
- Encourage professional prevention programs in the local school system.

Professional evaluation and treatment as soon as possible for the sexually abused child and the family is the best way to overcome the risk that the child will develop serious problems as an adult. The child and adolescent psychiatrist helps the child regain a sense of self-esteem and relieve feelings of guilt about the abuse; helps family members understand how to assist the child in overcoming the trauma; and, if the abuser is a member of the family, works to restore him or her to a healthy role in the family.

Teen Problems

Teenagers with Eating Disorders

Overeating related to tension, poor nutritional habits and food fads are relatively common eating problems for youngsters. In addition, two psychiatric eating disorders, anorexia nervosa and bulimia, are on the increase among teenage girls and young women. These two disorders also occur in boys, but much less often. The child and adolescent psychiatrist is trained to evaluate, diagnose, and treat these psychiatric disorders which are characterized by a preoccupation with food. Parents frequently ask how to identify symptoms of anorexia nervosa and bulimia. The fact is that many teenagers are for many months or years successful in hiding these serious and sometimes fatal disorders from their families.

Parents should be on the lookout for various symptoms and warning signs of anorexia nervosa and bulimia.

• A teenager with anorexia nervosa is typically a perfectionist and a high achiever in school. At the same time, she suffers from low self-esteem, irrationally believing she is fat regardless of how thin she becomes. Desperately needing a feeling of mastery over her life, the teenager with anorexia nervosa experiences a sense of control only when she says "no" to the normal food demands other body. In a relentless pursuit to be thin, the girl starves herself. This often reaches the point of serious damage to the body, and in a small number of cases may lead to death.

• The symptoms of bulimia are different from those of anorexia nervosa. The patient binges on huge quantities of high-caloric food and then purges her body of dreaded calories by self-induced vomiting and often by using laxatives. These binges may alternate with severe diets, resulting in dramatic weight fluctuations. Teenagers may try to hide the signs of throwing up by running water while spending long periods of time in the bathroom. The purging of bulimia presents a serious threat to the patient's physical health, including dehydration, hormonal imbalance, the depletion of important minerals, and damage to vital organs.

With proper treatment, teenagers can be relieved of the symptoms or helped to

control these disorders. Parents who notice symptoms of anorexia or bulimia in their teenagers should ask their family physician or pediatrician for a referral to a child and adolescent psychiatrist who works comprehensively in the treatment of these disorders.

Teen Suicide

Suicides among young people nationwide have increased dramatically in recent years. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15 to 24 year olds, and the sixth leading cause of death for 5 to 14 year olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up.

For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. In some cases, suicide appears to be a "solution."

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnose, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the symptoms of suicidal feelings are similar to those of depression. Parents should be aware of the following signs of adolescents who may try to kill themselves.

Child and adolescent psychiatrists recommend that if one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help when the concerns persist:

- Change in eating and sleeping habits.
- Withdrawal from friends, and family and regular activities.
- Violent actions, rebellious behavior or running away.
- Drug and alcohol use.
- Unusual neglect of personal appearance.
- Marked personality change.
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork.
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- Loss of interest in pleasurable activities.
- Not tolerating praise or rewards. A teenager who is planning to commit suicide may also:
- Complain of being "rotten inside."
- Give verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," "I won't see you again."
- Put his or her affairs in order—for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.

- Become suddenly cheerful after a period of depression.

If a child or adolescent says, "I want to kill myself," or "I'm going to commit suicide," always take the statement seriously and seek evaluation from a child and adolescent psychiatrist or other physician. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than "putting thought in the child's head," such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

With support from family and professional treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

Alcohol and Other Drugs

Most teenagers will have some experience with alcohol and other drugs. Most will experiment and stop, or continue to use casually without significant problems. Some will use regularly, with varying degrees of physical, emotional and social problems. Some will develop a dependency and be destructive to themselves and others for many years. Some will die, and some will cause others to die.

Some people grow out of their use of alcohol and other drugs. But since there is no certain way to predict which teenagers will develop serious problems, all use should be considered dangerous. Saying no is often part of the solution, but "just saying no" is seldom enough.

Some teenagers are more "at risk" than others to develop alcohol and other drug-related problems. Highest on the list are those teenagers with a family history Page - 86 of Substance Abuse problems. Legally available products include alcohol (over 21) and tobacco (over a certain age), prescribed medications, inhalants and over-the-counter cough, cold, sleep and diet medications. Illegal drugs include marijuana, cocaine/"crack," LSD, PCP, opioids, heroin and "designer drugs."

Although the use of some drugs has leveled off recently, the use of others has not. In particular, usage rates of alcohol, cigarettes and "crack" remain major areas of concern. Those who begin to smoke or drink during their early teens are at particularly high risk. These substances are the typical "gateway drugs" which lead first to marijuana, and then to other illegal drugs. Most adolescents continue using the earlier drugs as they begin using still others. Warning signs of teenage drug abuse may include:

- Physical: lasting fatigue, repeated health complaints, red and dull eyes, and a steady cough.
- Emotional: personality change, sudden mood changes, irresponsible behavior, low self-esteem, depression, and a general lack of interest.
- School: drop in grades, many absences, discipline problems.
- Social problems: new friends who are less interested in standard home and school activities, scrapes with the law, and changes to less conventional styles in dress and music.

Substance of the warning signs listed above can also be sings of other problems. Parents may recognize signs of trouble but should not be expected to make the diagnosis. An effective way for parents to show care and concern for their teenager is with them to honestly discuss the use and abuse of alcohol and drugs.

Consulting a physician to rule out physical causes of the warning signs is a good first step. This should often be followed or accompanied by a comprehensive evaluation by a child and adolescent psychiatrist.

How To Stop Smoking

Quitting smoking isn't easy, but millions of people have done it and so can you. These tips will help.

Getting Ready to Quit

- Set a date for quitting. Try to convince a friend to quit with you, so you' have mutual support.
- Notice when, where, and how you smoke. List the times when you usually light up—with morning coffee, after a meal, while driving, or whatever your usual smoking occasions are.
- Change your smoking routines. Keep your cigarettes in a different place, don't hold your cigarette in the hand you're used to using, switch brands, and don't carry on any other activity—like reading, driving, talking on the phone, or watching TV—while you smoke.
- Designate one place to smoke—like the back porch—and don't smoke anywhere else.
- When you want a cigarette, wait a few minutes before you light up. Try doing something else, like chewing gum or drinking a glass of water, and see if the urge passes.
- Buy only one pack of cigarettes at a time.
- Ask your doctor about medications that ease withdrawal symptoms and reduce cigarette cravings. You may want to have nicotine patches or gum on hand, ready for quit day.

On Quitting Day

- Get rid of all your cigarettes and put away your ashtrays.
- Change your morning routines, especially where and when you eat breakfast. Try sitting somewhere else, or going out to eat.
- When you get the urge to smoke, do something else instead.
- Carry substitutes to put in your mouth, such as chewing gum, hard candy, or toothpicks.
- Reward yourself at the end of the day. See a movie, or eat a favorite treat.

Staying Smoke-Free

- Don't be upset if you feel sleepy or short-tempered. These are symptoms of nicotine withdrawal, and they will go away in a few days.
- Exercise regularly. Go for walks, ride a bike, or take part in sports you enjoy.
- Think about the positive aspects of not smoking: your self-image as someone who's kicked a habit, the health benefits you and your family get from living in a smoke-free environment, the example you set for others.

- When you feel tense, think about the problem that's creating those feelings and try to solve it. Tell yourself that smoking won't make it better.
- Eat regular meals, so you don't have times when you feel hungry and confuse that feeling with the desire to smoke.
- Put the money you would have spent on cigarettes in a money jar every day, and watch it mount up. Plan to buy something special for yourself.
- Let other people know you have stopped smoking. Your friends who still smoke may want to know how you did it.
- If you break down and smoke a cigarette, don't give up. Many former smokers made several attempts to stop before they succeeded. Quit again.

Children with Disorders and Disabilities

Tic Disorders

A tic is a problem in which a part of the body moves repeatedly, quickly, suddenly and uncontrollably. Tics can occur in any body part, such as the face, hands or legs. They can be stopped voluntarily for brief periods. Sounds that are made involuntarily are called vocal tics. Most tics are mild and hardly noticeable. However, in some cases they are frequent and severe, and can affect many areas of a child's life.

The most common tic disorder is called "transient tic disorder," which may affect up to 10 percent of children during the early school years. Teachers or others may notice the tics and wonder if the child is under stress or "nervous." Transient tics go away by themselves.

Some tics do not go away. Tics which last one year or more are called "chronic tics." Chronic tics affect less than one percent of children and may be related to a special, more unusual tic disorder called Tourette's Disorder. Children with Tourette's Disorder have both body and vocal tics. Some tics disappear by early adulthood, and some continue.

Children with Tourette's Disorder may have problems with attention and concentration. They may act impulsively, or they may develop obsessions and compulsions.

Sometimes people with Tourette's Disorder may blurt out obscene words, insult others, or make obscene gestures or movements. They cannot control these sounds and movements and should not be blamed for them. Punishment by parents, teasing by classmates, and scolding by teachers will not help the child to control the tics but will hurt the child's self-esteem.

Through a comprehensive medical evaluation, often involving pediatric and neurologic consultation, a child and adolescent psychiatrist can determine whether a youngster has Tourette's Disorder or another tic disorder. Treatment for the child with a tic disorder may include medication to help control the symptoms. The child and adolescent psychiatrist can also advise the family about how to provide emotional support and appropriate educational environment for the youngster. Further information about Tourette's Disorder is available from The Tourette Syndrome Association, Inc., 42-40 Bell Boulevard, Bayside, NY 11361-2861, (718)224-2999.

Learning Disabilities

Parents are often worried and disappointed when their child has learning problems. There are many reasons for school failure, but a common one is a specific learning disability. A child with a learning disability is usually bright and initially tries very hard to follow instructions, concentrate and "be good" at home and in school. Yet despite this effort he or she is not mastering school tasks and falls behind. Some learning disabled children also have trouble sitting still or paying attention.

Learning disabilities affect as 15 percent of otherwise able schoolchildren. It is believed that learning disabilities are caused by a difficulty with the nervous system that affects receiving, processing or communicating information. Some learning disabled children are also hyperactive and/or distractible with a short attention span.

Child and adolescent psychiatrists point out that learning disabilities are treatable, but if not detected and treated early, they can have a tragic "snowballing" effect. For instance, a child who does not leam addition in elementary school cannot understand algebra in high school. The child, trying very hard to leam, becomes more and more frustrated, and develops emotional problems such as low self-esteem in the face of repeated failure. Some learning disabled children misbehave in school because they would rather be seen as "bad" than "stupid".

Parents should be aware of the most frequent signals of learning disabilities, when a child:

- Has difficulty understanding and following instructions.
- Has trouble remembering what someone just told him or her.
- Fails to master reading, writing, and/or math skills, and thus fails schoolwork.
- Has difficulty distinguishing right from left—for example, confusing 25 with 52, "b" with "d," or "on" with "no."
- Lacks coordination—in walking, sports, or small activities such as holding a pencil or tying a shoelace.
- Easily loses or misplaces homework, schoolbooks or other items.
- Cannot understand the concept of time; is confused by "yesterday," "today," and "tomorrow."

Such problems deserve an evaluation by an expert on the whole child and his or her health and mental health. A child and adolescent psychiatrist will work with the school professionals and others to have the necessary comprehensive evaluation and educational testing done to clarify if a learning disability exists. After talking with the child and family, evaluating their situation, reviewing the educational testing and consulting with the school, the child and adolescent psychiatrist will make recommendations on appropriate school placement, the need for special help such as special educational therapy or speech-language therapy and steps parents can take to assist their child in maximizing his or her learning potential. Sometimes individual or family psychotherapy will be recommended, and sometimes medication will be prescribed for hyperactivity or distractibility. It is important to strengthen the child's self-confidence, so vital for healthy development, and also help parents and other family members cope with the realities of living with learning disabilities.

Panic Disorder In Children and Adolescents

Panic disorder is a common and treatable disorder. Children and adolescents with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as racing heartbeat or feeling short of breath. These periods are called "panic attacks" and last minutes to hours. Panic attacks frequently develop without warning. Symptoms of a panic attack include:

- Intense tearfulness (a sense that something terrible is happening)
- Racing or pounding of heartbeat
- Dizziness or lightheadedness
- Shortness of breath or a feeling of smothering
- Trembling or shaking
- Sense of unreality
- Fear of dying, losing control, or going crazy

More than 3 million Americans will experience panic disorder during their life time. Panic disorder often begins during adolescence, although it may start during childhood, and sometimes runs in families.

If not recognized and treated, panic disorder and its complications can be devastating. Panic attacks can interfere with a child's or adolescent's relationships, schoolwork, and normal development. Children and adolescents with panic disorder may begin to feel anxious most of the time, even when they are not having panic attacks. Some begin to avoid situations where they fear a panic attack may occur, or situations where help may not be available. For example, a child may be reluctant to go to school or be separated from his or her parents. In severe cases, the child or adolescent may be afraid to leave home. This pattern of avoiding certain places or situations is called "agoraphobia." Some children and adolescents with panic disorder can develop severe depression and may be at risk of suicidal behavior. As an attempt to decrease anxiety, some adolescents with panic disorder will use alcohol or drugs.

Panic disorder in children can be hard to diagnose. This can lead to many visits to physicians and multiple medical tests which are expensive and potentially painful. When properly evaluated and diagnosed, panic disorder usually responds well to treatment. Children and adolescents with symptoms of panic attacks should first be evaluated by their family physician or pediatrician. If no other physical illness or condition is found as a cause for the symptoms, a comprehensive evaluation by a child and adolescent psychiatrist should be obtained.

Several types of treatment are effective. Specific medications may stop panic attacks. Psychotherapy may also help the child and family leam ways to reduce stress or conflict that could otherwise cause a panic attack. With techniques taught in "cognitive behavioral therapy" or "biofeedback therapy," the child may also leam new ways to control anxiety or panic attacks when they occur. Many children and adolescents with panic disorder respond well to the combination of medication and psychotherapy. With treatment, the panic attacks can usually be stopped. Early treatment can prevent the complications of panic disorder, contact the National Institute of Mental Health Panic Campaign, Room 15C-05, 5600 Fishers Lane, Rockville, MD, 20857, or call, 1-800-64-PANIC.

The Child With A Long-Term Illness

The child with a serious medical illness is at risk for developing associated psychological problems. Unlike a child with a temporary sickness such as the flu, the child with a chronic illness must cope with knowing that the disease is here to stay and may even get worse. Child and adolescent psychiatrists point out that almost all these children at first refuse to believe they are ill, and later feel guilt and anger.

The young child, unable to understand why the sickness has occurred, may assume it is a punishment for being "bad." He or she may become angry with parents and doctors for not being able to cure the illness. The youngster may react strongly against pampering, teasing, or other attention. Uncomfortable treatments, and restrictions in diet and activity may make the child bitter and withdrawn.

A teenager with a long-term illness may feel pulled in opposite directions. On the one hand, he or she must take care of the physical problem, requiring dependence on parents and doctors. On the other hand, the adolescent wants to become independent and join his or her friends in various activities. When a teenager with a long-term illness tries to decrease or stop taking the prescribed medication without consr king with the physician, this often shows a normal adolescent desire to take charge of one's own body.

Chronic illness may cause setbacks in school or avoidance of school. This can increase the child's loneliness and feeling of being different from or behind other youngsters. Parents who want to help their child in every way possible should respond not only to the child's illness, but also to his or her strengths. Child and adolescent psychiatrists know that ifoverprotected, the boy or girl may not leam to socialize or may have difficulty separating from parents when it is time to be involved in school. It is often helpful for the child to be in contact with others who have successfully adjusted to living with a chronic illness.

In their prolonged periods ofhospitalization and/or rest at home, children may develop excellence in a hobby or special talent such as art, model airplanes or a foreign language. They may also leam as much about their illness as possible. Such activities are psychologically healthy and should be encouraged.

Children with long-term illnesses are often treated by a team of medical specialists which may usefully include a child and adolescent psychiatrist, who can help the child and family develop psychologically healthy ways of living with the disease and its effects.

Taking Your Medications and Prescriptions

For millions of people who suffer form a chronic disease such as high blood pressure or diabetes, or from an occasional bacterial illness, taking prescription medication offers relief from symptoms and improves health.

As the number of prescription drugs continues to grow in the United States, the potential for problems also increases. When prescription drugs are not used as directed, they can cause serious problems by failing to relieve the symptoms, creating health complications, or even causing death.

Health care professionals are trying to improve the process of prescribing and delivering necessary medications to reduce the possibility of errors. Researchers reporting in the July 21,1999, issue of JAMA found that including a pharmacist in the patient care team on rounds in the intensive care unit, where a high volume of drug prescriptions are administered, reduced medication errors.

Things To Do:

- Take a prescription drug in the exact amount and schedule prescribed by your doctor.
- Call your doctor right away if you have any problems with your medicine.
- Inform your doctor about any other medicines (prescription or nonprescription) that you are taking and if you have any allergies to medicines or other medical conditions at the time a drug is prescribed.
- Be sure you understand all instructions about taking the drug before you leave your doctor's office, and write down or ask for written instructions for future reference. Drug labeling information can change, so read the prescription label each time you fill it.
- Keep a record of all medicines (prescription and nonprescription) you are taking. Keep a copy in your medicine cabinet and in your wallet; share the record with each new doctor you see.

Things Not To Do:

- Don't demand any particular drug (such as antibiotics or medicines you may have seen advertised) from your doctor if your doctor explains why you don't need them.
- When directed by your doctor to take a prescription drug, don't stop taking a drug after a few days because you feel better or because you don't feel better. Some drugs may provide immediate relief of symptoms, while other drugs take longer to show benefit. It is important to complete the full course of treatment for the drugs to be safe and effective.
- If you are considering stopping or stop your medicine, contact your doctor.
- Never take any medicine that has been prescribe for someone else, and don't give your prescribed medicine to anyone else.
- Do not consume alcoholic beverages with any medicine until you check with your doctor.

- If you are pregnant, do not take any medicine before checking with your doctor.

Things To Discuss With Your Doctor:

At the time that your doctor gives you a prescription, you should understand the following information:

- The name of the medication and what it is supposed to do.
- How and when to take it, and for how long.
- What foods, drinks, other medicines, or activities to avoid while taking the medicine.
- Any side effects, and what you should do if they occur.
- Whether the new prescription will work safely with other prescription and nonprescription medicines, supplemental vitamins, or herbal or alternative therapies you may be taking.
- Any written information available about the medicine.

Stress of Parenting

Being a parent can be a true joy, but it isn't easy. Parenting is a round-the-clock job with many concerns and demands that can be very stressful. When you factor in caring for and worrying about the health of a child or newborn with medical problems, the stress increases.

In an article in the March 3,1999, issue of JAMA, researchers found that mothers of very low-birth-weight babies had higher levels of stress than mothers of babies with average birth weight. They also found that mothers who had very low-birth-weight babies with medical complications had an even higher level of stress and that they continued to have higher levels of stress even 2 years after the birth of their child.

To effectively manage the stress of being a parent and the caregiver of a sick child, it is important to recognize the accumulation of stress from each role.

What To Do About Stress:

- Take a breather (deep breathing can quickly and effectively relieve stress)
- Take a break (even a short break of 5 minutes can provide stress-relieving benefits)
- Make time for yourself (provide regularly scheduled breaks by having a reliable and trusted person help with parenting duties or enroll your child in a certified daycare program)
- Make time for exercise and regular daily activities
- For severe stress, seek the help of a physician or other health care professional

Signs Of Too Much Stress:

- Feeling tired and irritable most of the time
- Feelings of being down or low that last more than a few days
- More than usual difficulty concentrating and making decisions
- Difficulty enjoying regular activities that used to give pleasure
- Feelings ofworthlessness, helplessness, hopelessness, or guilt
- Loss of appetite
- Sleeping problems
- Loss of sexual desire

How To Minimize Stresses Of Parenting:

- Share household responsibilities and chores with other members of the household (spouse, partner, even older children when appropriate).
- Set realistic rules for children and stick by them.
- Try to maintain a fairly regular schedule for children, including set meal times and bed times.
- Have realistic expectations of your children's behavior and respect their individuality.
- Don't sweat the small stuff. Many little problems and mistakes that children make are not worth getting upset over—just let them go.

RECORD OF ILLNESS, INJURY OR HOSPITALIZATION

Date	Age	Illness/Hospitalization Accident/Injury

RECORD OF ALLERGY OR SENSITIVITY

Date	Age	Allergy/Sensitivity

METRIC CONVERSION INFORMATION

Symbol	**When You Know the Number of**	**Multiply by**	**To find the Number of**	**Symbol**
cm	centimeters	0.39	inches	in.
in.	inches	2.54	centimeters	cm
kg	kilograms	2.205	pounds	lb.
lb.	pounds	16	ounces	oz.
lb.	pounds	0.454	kilograms	kg
oz.	ounces	28.35	grams	g
		Divide by		
g	grams	1,000	kilograms	kg

GROWTH RECORD

Date	Age	Length	Weight
	Birth		

Date	Age	Immunizations								Procedures					Physician
		DTP (diptheria, tetanus, pertusis)	DT (diptheria, tetanus)	Tetanus toxoid	TOPV (trivalent oral poliovirus vaccine)	Measles Vaccine	Rubella (German measles vaccine)	Mumps Vaccine	H. influenze (Hib)	Tuberculin test	Hemoglobin	Urinalysis	Urine culture	Other	

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		see footnote 1	HepB						
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV4	

Range of recommended ages

Certain high-risk groups