



Pediatrics East

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*Experts In the Practice of
Pediatric and Adolescent Medicine*

OFFICE LOCATIONS

8110 Walnut Run, Cordova, TN 38018, Phone: 754-9600
2002 Exeter Road, Germantown, TN 38138, Phone: 757-3570
2004 Exeter Road, Germantown, TN 38138, Phone: 757-3530
120 Crescent Drive, Collierville, TN 38017, Phone: 757-3560
8025 Stage Hills Blvd., Bartlett, TN 38133, Phone: 757-3540

After Hours Line: 937-6140
Appointment Line/Nurse Line: 757-3535

**Visit our Website at:
www.Pedseast.com**

PEDIATRIC HANDBOOK

Edition 05/08

Doctor Locations

	Exeter	Cordova	Collierville	Bartlett	Off
Monday	Senter	Larkin	Hayes/A.M.	Scott	Threlkeld
	Hussain	Higginbotham	Fesmire	Benaim	Hayes
	Davis	Adams	Gunter	Owen	Aguillard
	Edwards/04	Nearn	Newman Mitchell	Bagley	Montgomery
Tuesday	Senter	Threlkeld	Fesmire	Scott	Benaim
	Edwards/04	Larkin	Gunter	Montgomery	Hussain
	Davis	Aguillard	Newman	Owen	Bagley
	Hayes/2-6:30	Higginbotham	Mitchell	Bagley	Adams
Wednesday	Senter	Threlkeld	Fesmire	Scott	Higginbotham
	Edwards/04	Larkin	Hayes	Montgomery	Gunter
	Hussain	Aguillard	Newman	Benaim	Davis
		Adams Nearn	Mitchell	Owen	
Thursday	Senter	Threlkeld	Fesmire	Scott	Newman
	Edwards/04	Larkin	Hayes	Montgomery	Owen
	Hussain	Higginbotham	Gunter	Benaim	Mitchell
	Davis	Nearn		Bagley	
Friday	Hussain	Higginbotham	Hayes	Benaim	Threlkeld
	Davis	Adams	Gunter	Montgomery	Larkin
		Nearn	Newman	Owen	Fesmire
			Mitchell	Bagley	Senter
					Scott Edwards

INTRODUCTION

This handbook is designed to answer many common questions asked by parents. However, no handbook will ever answer all of your questions. WHEN A PROBLEM ARISES WITH YOUR CHILD, PLEASE CONSULT THIS HANDBOOK FIRST. If your concern remains unanswered, please call the office or After Hours Line for guidance. Our first concern is your child's welfare.

GENERAL OFFICE INFORMATION

Please make an appointment for all office visits. Our regular office hours are 9:00 a.m. to 5:00 p.m. Monday to Friday. Urgent visits and emergencies will by necessity take precedence over appointments, and may unexpectedly delay your doctor. Please forgive our tardiness when the unexpected occurs.

We offer extended hours outside of traditional business hours, because children can become ill at any time. We do not schedule well child care or chronic illness care during our extended hours, as they are intended for immediately ill children. Visits made during these extra available hours incur extra charges.

OFFICE HOURS

- Weekdays** Office phones answered 9:00 a.m. - 5:00 p.m.
Doctors' appointment hours 9:00 a.m. - 1:00 p.m.
and 2:00 p.m. - 4:30 p.m.
Before hours Walk In Clinic*: 7:30 a.m. - 8:00 a.m.
at 2002 Exeter in Germantown
- Weeknights*** By Appointment Only after 6:00 p.m.
Monday through Thursday
2002 Exeter in Germantown
Call 757-3570 After 5:00 p.m. for advice and scheduling
- Saturdays*** By Appointment Only 9:00 a.m. to 12:00 p.m.
8110 Walnut Run in Cordova
Call 754-9600 after 8:00 a.m. for scheduling
- Sundays*** By Appointment Only 1:00 p.m. to 3:30 p.m.
8110 Walnut Run in Cordova
Call 754-9600 After 12 noon for scheduling

*There is an additional charge for all visits outside of our regular business hours

APPOINTMENTS

To schedule an appointment, please call the appointment line at 757-3535 and press option #1. The appointment line is open Monday through Friday from 7:30 a.m. until 4:30 p.m.

Checkups should be scheduled at least one week in advance, in the office where your child's chart and usual physician are located. Sick appointments may be made the same-day or in advance.

Out-patient shots and lab work are scheduled by calling 757-3535.

We try and see as many of our ill patients on the same day, preferably by their own doctor. Patients who fail to keep appointments impose a burden on others who could have been seen, and we therefore charge a fee of \$50.00 for 'no shows.'

EMERGENCIES

If a true emergency arises, call 911 for emergency transport to Le Bonheur Children's Hospital, or to the nearest available emergency room. Have the emergency room staff contact our office or After Hours Line on arrival. For urgent problems, which are not emergencies and occur during office hours, call your physician's office and explain the nature of your problem. A member of our clinical staff, or physician, will direct you based on their best estimate of the level of care required for your concern. Call the After Hours Line (937-6140) for urgent problems which are not emergencies that arise outside of office hours and cannot wait until one of our clinics is open. Please be certain you understand your insurance company's requirements regarding preferred hospitals or after hours care facilities.

PHONE CALLS

For your convenience, members of our clinical staff are available for telephone advice Monday to Friday from 9 a.m. to 5 p.m. A medical staff member will return your call as quickly as possible, and assist you in addressing your concern. If there are special considerations requiring a more intimate knowledge of your child's condition, your call will be forwarded to the individual best able to provide the required care.

We understand that everyone occasionally needs to talk with a physician regarding a condition not requiring an office visit. Should this be the case, a physician will return your call as soon as the opportunity presents: usually between 1 p.m. and 2 p.m., or after 5 p.m.

For urgent problems arising after normal office hours, call our After Hours Line at 937-6140. Your call will be directed to a clinical staff member, trained in the use of nationally recognized protocols for the care of children. If need be the on call physician will be contacted. Pediatrics East physicians rotate after hour responsibilities, so your physician may not be on call when your concern arises.

If you call regarding a prescription refill, please have your pharmacy phone number available. Antibiotics, narcotics and steroids cannot be prescribed without your child first having been seen by a physician. Certain medicines are forbidden by law from being called in, and we will not do it. We never call in medicines for non-Pediatrics East patients.

INSURANCE

We require that you present your insurance card at each visit and update any information needed to help us file your insurance correctly. It is the responsibility of all parents to know their insurance coverage, and the amount of the co-pay to be collected at the time of service.

The doctors of Pediatrics East participate in many PPO, POS, and HMO plans. If your insurance is a PPO or HMO plan in which we do not participate, you will be responsible for all charges incurred. If your insurance requires specific facilities for lab work, etc., please inform us and we will try to abide by those requirements. We cannot, however, be responsible in the event care is provided or testing is done at a facility not approved of by your insurance.

REFERRALS

We need at least 72 hours advance notice to complete a referral to a specialist. Sometimes it takes longer if there are additional insurance hurdles. It is your responsibility to notify your pediatrician's office well in advance with specific information regarding: who the patient is, whom they will see, when they will be seen, why you have scheduled the appointment with the specialist, and particulars of the insurance coverage which will be used. Without this we will not be able to properly process your referral, delaying your receipt of needed care. Patients who arrive at a specialist referral office without the necessary prior planning and insurance approval may find that they will have to reschedule their appointment.

SELECTED MEDICAL TOPICS

ANEMIA	IMMUNIZATIONS
ANTIBIOTICS	IMPETIGO
BEDWETTING	LICE
BOWEL MOVEMENTS AND HABITS	NOSEBLEEDS
CHICKENPOX	OTITIS EXTERNA (SWIMMER'S EAR)
COLIC	OTITIS MEDIA (MIDDLE EAR INFECTION)
THE COMMON COLD	PHARYNGITIS (SORE THROAT)
CONJUNCTIVITIS (PINK EYE)	PINWORMS
CROUP	RINGWORM
DERMATITIS	SCABIES
DIAPER RASH	SEIZURES AND FEBRILE SEIZURES
DIARRHEA	SLEEP
FEEDING DURING THE FIRST YEAR	TEETHING
FEEDING DURING THE FOLLOWING YEARS	THRUSH
FEVER	THUMB SUCKING AND PACIFIERS
HEAD INJURY	VOMITING

ANEMIA

Iron deficient anemia is the most common form of malnutrition in the United States. Beginning at one year of age we screen for this anemia with a blood test. If your child's blood count is low, your doctor will prescribe iron in the form of drops or pills to correct the anemia. There are a few things you can do to assure that your child's blood iron remains at normal levels.

1. During the first year of life, your child should be given either breast milk or infant formula with iron, not whole (cow) milk, goats' milk, or 2% milk. If your child is breastfed, a multivitamin with iron may be prescribed by your doctor. Mothers who are breast feeding should continue to take their pre-natal vitamins with iron for the duration of their breast feeding.
2. Children over the age of one may take a chewable multivitamin with iron in addition to eating a balanced, iron containing diet. Dietary sources of iron include: liver, pork, beef, chicken, iron-fortified cereals, prune juice, dried beans and peas, eggs, tuna, peanut butter, cooked greens, tomato juice and pasta.

ANTIBIOTICS

Most people take antibiotics for granted and consider them "magic bullets" that are good for colds, viral sore throats and the flu. Unfortunately, the use of antibiotics for such conditions is inappropriate, ineffective, and a waste of your money. Misuse of antibiotics can allow bacteria to become resistant, resulting in "super bugs."

Antibiotics kill only bacteria, and when used properly they are effective. They do not work against viral infections. Though antibiotics are useful in treating many illnesses, some bacteria have become tougher to kill because they have found a way to fight the antibiotic being used against them. These stronger bacteria are called “resistant”, making illness caused by them more difficult to treat, and require even more powerful antibiotics. **Overuse of antibiotics increases the chance that your child will get sick with resistant bacteria.**

Your doctor will determine if your child needs an antibiotic, and which one to use.

- Cold and flu—are caused by viruses. Antibiotics do not work against viruses. Rest and liquids are usually adequate to manage the symptoms of a cold or flu, which may last as long as two weeks. Annual flu shots are a wise precaution.
- Cough or bronchitis—Viruses are the most common cause of these ailments. A bacterial infection should be considered if your child’s condition persists, or if they have accompanying lung problems such as asthma.
- Sore throat—Viruses are the most common causes of sore throats. Strep throat is a special bacterial throat infection requiring treatment with antibiotics.
- Ear infections—Bacteria cause approximately half of all ear infections. Several types of ear infections are not treated with antibiotics.
- Sinus infections—Are not always caused by bacteria, even if you have a runny nose, or yellow or green mucus coming from your nose. A bacterial infection is more likely if symptoms are severe, or last more than two weeks, and using selected antibiotics would be appropriate based on the doctors’ examination.

BEDWETTING

Bedwetting is more common in boys than in girls, and often there is a family history of the problem. The cause in most cases is unknown, but probably simply represents a delay in development of normal bladder control. A visit with your physician is necessary to rule out obvious anatomical or medical problems. Occasionally a specialist is consulted depending on the circumstances.

The treatment of bedwetting can be frustrating both for the child and the family. Try to enlist your child’s cooperation in solving this problem, motivating him with small rewards for dry nights. Other helpful hints include:

1. Bladder strengthening exercises: Have your child hold back the urge to urinate for slowly increasing periods of time. The object is to hold as much urine as possible, without pain, to increase bladder capacity.
2. Stream interruption exercises: Have him stop urine flow during urination, count to 10, and then finish voiding. The increased strength and control of bladder sphincter function while awake may help while asleep.
3. Limit the amount of fluids consumed after supper.

4. Awaken your child before you go to sleep for a bathroom visit.
5. Have your child take responsibility for changing the linens after “an accident.” Never criticize or punish him. It is unnecessary and cruel to heap shame on him.

If questions or problems persist, call or visit your child’s doctor. We can discuss other interventions including alarm conditioning and medication.

BOWEL MOVEMENTS AND HABITS

Parents of small infants are often concerned with the quality, quantity and frequency of their child’s stool. This is an important concern but seldom cause for great worry, as there is great variation in what is considered ‘normal’. No infant has the same stool pattern as another. Although breastfed babies tend to have more watery and more frequent stool than formula fed babies, this is not always the case. It is also normal for babies to grunt and strain to expel their stool.

If your child has extremely thick pasty stools, or passes little firm balls, he or she is probably constipated. The stool can be softened by giving your baby an ounce of water occasionally between feedings and (or) adding 1 or 2 teaspoons of dark Karo syrup or mineral oil to every 2 oz. of formula.

Many parents believe that the iron in infant formula causes constipation. It does not.

If your baby goes 2 or 3 days without stooling, you may use a glycerin suppository if they seem uncomfortable. Keep in mind that suppositories should not be used routinely as they only relieve the problem temporarily, and are not a solution. Contact your doctor if problems persist.

Older children’s constipation can be treated by increasing water intake, increasing dietary fiber, using mineral oil, or giving Metamucil, Citrucel, or MiraLAX according to package directions. The most common cause of constipation in children after infancy is inadequate fiber in the diet.

CHICKENPOX

Chickenpox has greatly decreased in recent years, thanks to vaccinations. It is an infection that occurred in most children by age ten, but still occurs on occasion. You should know how to recognize it.

Beginning with a cold-like illness for a couple of days, the first sign of chickenpox is a cluster of red dots on the chest or face. Over the following hours more clusters of spots appear, which evolve to look something like fire ant bites, then crust over after a couple of days.

It only takes a couple of days before the patient is covered in spots, which are well known for their itchiness. Because itching naturally leads to scratching we recommend you cut your child’s nails short and use oral Benadryl and Tylenol to minimize the discomfort. Scratched pox spots are prone to scar, so discourage scratching! Do not give your child aspirin when he/she has chickenpox.

COLIC

Colic is a problem in some infants, usually under three months of age. Typical colic is manifested by: a fretful, unhappy baby who cries a lot, especially at night; seems to want to eat all the time; and/or appears to have stomach pain, pulling thighs up to the abdomen and expelling large quantities of gas.

All crying babies do not have colic. Excessive crying may be due to improper feeding techniques, tension in the family, milk allergy, reflux, or pain elsewhere in the baby (earache, urine infection). If you have questions about whether your child might have colic, consult your child's doctor or nurse. There are several things you can do to help your baby feel relaxed and restful:

1. Make sure your baby is getting enough to eat. Breastfed babies should be offered both breasts at each feeding. (You may want to offer the baby water after the feeding.) If bottle fed, offer more formula to the baby.
2. Hold your baby upright while feeding. Taking milk lying down may result in swallowed air. Burp and soothe baby often during feeding.
3. Offer a pacifier to soothe your baby.
4. Your child may be soothed by: a car ride, rocking in a chair with you with baby lying belly down on a hot water bottle in your lap, sitting in an infant carrier on top of your clothes dryer (Make sure the carrier is secure and do not leave unattended), or wrapping your baby snugly in a pre-warmed blanket.
5. Do not force feed your baby. Constant feeding only makes a colicky baby worse. You may try offering a small amount of water between feedings if baby seems hungry.
6. Your baby may have 1/4 tsp. of Maalox Plus or Mylanta II, or simethicone (Mylicon) drops no more than four times a day for excess gas.

If the above measures fail, consult your physician during office hours. Call your doctor for advice and have a pharmacy phone number ready in case a prescription should be needed. Remember that colic does not harm your baby and that you are not responsible for your baby's colic.

THE COMMON COLD

Everyone, at one time or another, is going to catch a cold. Colds are due to viruses coming from the infected nose or throat of another person. In general, a cold begins with watery discharge from the nose, with sneezing and watery or "weak" eyes. Cough and/or sore throat, especially at night or upon waking, may accompany the cold. Children may run fever for 2 to 3 days. If the nasal drainage becomes thicker, your child may be bothered by a stopped up nose or increased amount of coughing. Colds run their course and disappear in 10 – 14 days unless complicated by ear infection or other problems. A child who seems to "keep a cold" year round may have allergies, and parents should consult a doctor. Also, yellow/green colored mucus is normal for 2 – 3 days with a cold.

The treatment of a cold consists of making the child more comfortable and lessening the chances of complications. Medical science has yet to discover any cure for a cold. Here is a list of things you should know about managing your child's cold.

1. Babies with congested nostrils are unhappy and feed poorly. We recommend the use of saline nose drops in each nostril followed by suctioning out the nostril with a nasal aspirator (if necessary). This may be repeated as often as necessary until the nasal airway is open, and may be repeated as often as needed throughout the day. Repeated use of bulb suctioning which is unsuccessful irritates the nasal passages and is discouraged. MIX 1/4 TSP. SALT AND 1/4 TSP. BAKING SODA IN 8 OUNCES OF WATER TO MAKE SALINE NOSE DROPS.
2. Give Tylenol if the baby is uncomfortable or fretful.
3. Expect your child's appetite to decrease with a cold. Encourage lots of fluids, but never force food or drink on your child.
4. Do not overdress your child. A room temperature of 68-74 degrees is recommended. If they are old enough to make themselves comfortable, let them do so.
5. Do not start the leftovers from any antibiotic prescription, as these drugs will not cure the cold and may mask potentially serious infections. Old liquid antibiotics should never be kept anyway, as they go bad.
6. If the cold lingers for more than 14 days, or your child's fever persists over 101 degrees for 5 or more days, your child should be seen in the office.

The FDA (Food and Drug Administration) and AAP (American Academy of Pediatrics) advise against the routine use of over-the-counter cold medicines in children. Consult with your doctor regarding symptom relief medication for colds before using them.

CONJUNCTIVITIS (PINK EYE)

Conjunctivitis is inflammation of the thin tissue that covers the eyeball. This may be caused by a viral or bacterial infection, but can also be caused by allergy, trauma, or chemical injury to the eye.

Treatment of most episodes of infectious conjunctivitis includes eye drops or ointment. If you are prescribed an antibiotic, follow the prescription instructions. If there is no improvement in 3 to 4 days, call the office. Call immediately if increased swelling or redness develops in the eyelids.

CROUP

Croup is a viral infection causing an unusual "barky" or "seal-like" cough. Sometimes there is difficulty breathing in, causing a noise called stridor. There is not usually much fever associated with this illness.

You can help your child by using a cool mist vaporizer, or humidifier, in the bedroom. If stridor develops (usually at night) you can often relieve it by letting

your child breathe steamy shower air in the bathroom. If 10 to 15 minutes with the shower doesn't give enough relief, try cool air (sitting in front of the open refrigerator). In the winter months, bundle up and go outside. If these ideas fail to relieve your child's distress, call your doctor or seek help at the nearest emergency room.

DERMATITIS

Dermatitis is inflammation of the skin due to contact irritants, allergies, heat, etc. If your child's skin becomes excessively reddened, swollen, crusty, scaly, or has open sores, call the office for instructions or make an appointment.

Otherwise, your child's skin rash can usually be treated by:

1. Applying a moisturizing lotion such as Eucerin.
2. Washing with a gentle soap such as Dove or Cetaphil.
3. Using a steroid cream or ointment prescribed by your child's doctor when necessary.

Keep in mind that infants will acquire a variety of rashes during the first few months, and these rashes seldom require treatment. For most rashes, it is most effective to remove the cause of irritation from the environment.

DIAPER RASH

All babies suffer diaper rash or skin irritation at some time. Diaper rash can result from urine ammonia or stool on the baby's skin for too long, irritant or allergic reactions to commercial diapers or diaper wipes, or from a yeast infection. Your child's doctor can prescribe the best treatment once he or she has determined the cause. For any diaper rash, the following will help the rash:

1. Change the diaper when soiled, both day and night.
2. Increase the baby's fluids to dilute urine and ammonia content.
3. Clean the diaper area gently but thoroughly with warm water at each diaper change. Allow the area to air dry completely afterwards.
4. Apply a water repellent agent such as Desitin, zinc oxide, A & D Ointment.

If the rash persists, or spreads, call the office.

DIARRHEA

When your child has diarrhea, it is important to encourage liquids to prevent dehydration. Signs of dehydration (dry from losing water) are dry skin, sunken eyes, dry lips and mouth, and limited or no urine production.

For infants under one year of age:

1. Breast fed: Continue breastfeeding, there is rarely a reason to stop nursing. Your child may prefer smaller (shorter) feedings more often,

allowing adequate absorption. If the diarrhea is persistent contact your doctor for further advice. Occasionally additional fluids are necessary, and can be given with a commercially prepared oral rehydration solution such as Pedialyte, Gerber electrolyte, or Infalyte. If the child is already on solids, those may be continued.

2. Formula fed: There is no reason to stop formula with diarrhea only. It may be necessary to give smaller amounts more often to give the stomach a chance for absorption.

Extra fluid intake is usually needed and can be provided by an oral electrolyte solution. Never prepare concentrated or powdered infant formula with Infalyte, Pedialyte, or another oral electrolyte solution.

For the older child with diarrhea, offer oral electrolyte replacements. Do not offer fruit juices to a child who has diarrhea. You may continue solid foods, as long as your child is not vomiting. Recommended foods include bananas, rice cereal, toast, crackers, cookies, potatoes (mashed or baked). As the diarrhea resolves, advance the diet slowly emphasizing starchy foods such as potatoes, bananas, and macaroni.

Oral electrolyte solutions are usually well accepted by young children. If not, the taste can be improved by adding 1/4th teaspoon of Pre-Sweetened Sugar Free Kool-Aid to 8 ounces of solution. If you use unsweetened Kool-Aid, add 1/8th teaspoon of the Kool-Aid and either 2 packages of Equal or 1 package of Sweet'N'Low to 8 ounces of solution.

Over-the-counter anti-diarrheal agents may be given with caution to treat diarrhea (for no more than 3 days), but consult your child's physician first as there are illnesses where this is not appropriate.

Recommended Imodium AD dosages:

6 – 8 years old (48 – 59 lbs.): 2 teaspoonfuls after first loose bowel movement, followed by 1 teaspoonful after each subsequent loose bowel movement. Do not exceed 4 teaspoonfuls a day.

9 – 11 years old (60 – 95 lbs.): 2 teaspoonfuls after first loose bowel movement, followed by 1 teaspoonful after each subsequent loose bowel movement. Do not exceed 6 teaspoonfuls a day.

Do not use Adult Pepto-Bismol in children under 12 years old, for patients with chickenpox, or if there is a possibility of an Influenza infection. (Adult Pepto-Bismol contains a chemical related to aspirin, which should be avoided in these illnesses). If you do use Pepto-Bismol, you should know that it frequently turns the tongue and stool black. This is temporary.

Most cases of diarrhea can be managed without seeing a doctor. However, if the diarrhea persists more than 2 or 3 days, or if you feel you can't keep up with the fluid losses in the stool, call your doctor to see if any changes need to be made. If the diarrhea is accompanied by persistent abdominal pain, lasts longer than a week, or if there is bloody or black-tar like stool, see your

physician. If bloody or tar-like stool is the concern, bring some with you in a sealed plastic container.

Remember that the smaller the child, the more rapidly he/she can become dehydrated. If you have any questions, call the office.

FEEDING DURING THE FIRST YEAR

We strongly encourage breast feeding for all babies. If formula feeding is chosen, we recommend commercially prepared milk formulas such as Enfamil Lipil or Similac Advance with iron. Breastfeeding or using infant formula provide all the calories, water and nutrients that your baby will require during the first four months of life. Regular cow milk is not balanced nutrition for an infant, and the iron in it is difficult for the baby to absorb. Avoid goats' milk, as it has no iron and very little nutritional value, and you will soon have a very sick baby on your hands.

You should always discuss starting solids with your child's doctor.

The goal of introducing solids for a breastfeeding infant is to augment breast feeding. Therefore it is recommended that the baby nurses first, and the baby is offered solids after nursing. Iron fortified cereal is the recommended first food. Our lactation consultant can assist you with this endeavor if you have questions.

The goal of introducing solid foods in a bottle fed infant is to provide your child with a more balanced diet as they grow. Iron-fortified cereal is recommended as your baby's first solid food. Dry cereal can be mixed with water, breast milk, or formula to a pleasant consistency (not too runny or gummy). Start with rice cereal for a few days, and over several weeks you may try oat and barley cereals as well, if you wish. Avoid mixed grain cereals, rye, cream of wheat, or gluten supplemented cereals. Use a spoon rather than the bottle, since you are training the child for the eventual introduction of other foods.

Since different foods can cause different allergies in certain individuals, we always recommend introducing only one new food at a time into your baby's diet. You should then continue that food 4 – 5 days, looking for signs of intolerance (vomiting, diarrhea, skin rashes, colic, runny nose, irritability, or difficulty sleeping) before introducing the next new food. If a food causes any of these symptoms, it should be discontinued temporarily and tried later. Repeated difficulties should be discussed with your doctor at the next well visit. Each feeding should be followed by formula or water. The amount that your child should eat depends on his or her hunger at the time.

The next food group to introduce is usually vegetables. Please consult with your child's doctor regarding their individual food introduction preferences. Begin your exploration of vegetables with the yellow ones (squash, carrots, sweet potatoes), then move on to the green vegetables, still introducing one new food every 4 – 5 days. When you begin fruits you should feed only individual fruits, not mixed fruits or fruit cereals, advancing as before. After your baby has tried all of the individual foods above, food mixtures may be fed for the sake of variety and convenience. Meats and eggs are usually delayed until 9 months of age.

Do not feed your baby honey until after 1 year of age. Consult your doctor before starting strawberries, tomatoes, fish, eggs, nuts or peanut butter.

Pediatrics East has associated with Cindy Earle, a breast feeding expert, who is available to help with lactation issues. She has provided the following for us to include in the Yellow Book:

Although breastfeeding is a natural way to feed your child, it is a learned behavior that may require the expertise of a lactation consultant. A lactation consultant has the knowledge and experience to assist mothers and babies in this endeavor, and assisting in special situations. The physicians of Pediatrics East recognize the benefits of breastfeeding, and the benefit of having a professional on staff that is available to dedicate the time necessary to encourage and assist you in meeting your infant feeding goals. If I may be of assistance, please request a consult through your physician, the appointment line, or by calling me directly at 853-8307.

Respectfully,

Cindy Earle, RN, IBCLC

FEEDING DURING THE FOLLOWING YEARS

We recommend that your child drink whole milk during the second year of life, preferably 16 – 24 ounces per day. After age 2, we recommend low fat milk (according to family preference).

Your child's appetite will vary from month to month, and even from meal to meal. Do not be concerned by a temporary decrease in appetite. Toddlers are famous for having temporary appetite slumps. Very likely it will be followed shortly by an increased appetite. We are more interested in long term steady weight gain than by short term changes in appetite.

Offer your child foods from all food groups each day. Encourage your child to at least try each food on his/her plate. Avoid becoming a "short order cook" for your child. Meals should be the same for all members of the family, if possible. We discourage "grazing," which allows a child to fill up on snack foods between meals, and decreases appetite at meal times. Carrying around a "sippy cup," constantly full of juice, has the same effect. Younger children, however, do benefit from a scheduled snack in the morning and afternoon between meals, and water should always be available between meals. It is helpful to have meal times on a regular schedule each day.

Foods such as hot dogs, peanuts, grapes, raisins, apples or popcorn are a very real choking hazard for small children and if given should be cut into small irregular shapes which reduces the chance of choking .

FEVER

Fever is a temperature inside the body of 100.4F degrees or more. Normal childhood temperatures range between 97 – 100° Fahrenheit, and 98.6°F is the average of these (i.e. 99°F is not fever.) Body temperature is best measured with an oral, rectal, or ear thermometer (used in the appropriate place). Axillary (armpit) and forehead temperatures can be misleading, and we discourage your using them when you are truly concerned about the severity of a fever.

Fever itself is not an illness, but one of the signs that your child is ill. It is one of the body's many defense mechanisms to fight infection. Fever increases the activity of other parts of the immune system, improving function of white blood cells, antibodies and other infection fighting systems. Fever also slows down the multiplication of viruses and bacteria, which helps slow down the infection and allows your child to recover more quickly. Fever is not an enemy, so keep your child comfortable, well hydrated, and allow the natural defense of your child fight the infection.

The fever caused by an infection does not cause brain damage, even fever over 105°F. The most frightening potential side effect of a fever is a seizure. The good news is that a seizure caused by a fever is harmless to the child, and occurs in fewer than one in twenty children.

If your child is uncomfortable, fever can be managed by:

1. Removing all excess clothing, leaving your child in a t-shirt and diaper or underwear.
2. Offering cold liquids, ice chips and popsicles.
3. Giving Tylenol or other acetaminophen product every 4 hours at recommended doses (Drops 80 mg/0.8 ml, Liquid 160 mg/tsp, and Infant Chewable tablets 80 mg/tab).

Dosing Chart for Acetaminophen

	Drops	Liquid	Chew tabs
Over 2 months	0.4 ml	1/4 tsp	1/2 tab
12 – 17 pounds	0.8 ml	1/2 tsp	1 tab
18 – 23 pounds	1.2 ml	3/4 tsp	1 & 1/2 tab
24 – 35 pounds	1.6 ml	1 tsp	2 tabs

4. Acetaminophen can take up to 45 minutes to begin lowering your child's temperature. If a high fever persists (over 104 degrees), remove all of your child's clothing and bathe your child's skin with warm water (about skin temperature). Do not bathe your child in alcohol or cool water (cool water will make them shiver—defeating the purpose of the bath).
5. Never give ibuprofen (Motrin) to infants under 6 months. In children over 6 months you may give ibuprofen (Drops 50mg/1.25ml, Liquid 100mg/5ml, or chew tabs 100mg/tab) every 6 hours at the recommended doses.

Dosing Chart for Ibuprofen

	Drops	Liquid	Chewable
12 – 17 pounds	1.25ml	1/2 tsp	---
18 – 23 pounds	1.875ml	3/4 tsp	---
24 – 35 pounds	2.5ml	1 tsp	1 tab
36 – 47 pounds	---	1 & 1/2 tsp	1 & 1/2 tab
48 – 59 pounds	---	2 tsp	2 tab

In the past it was common practice to alternate the administration of Tylenol and Motrin in ill children whose fever did not seem to respond to one medication alone. Recent evidence suggests this is not always safe. Consult with your doctor before you do this.

Fever is always concerning during the first 2 months of life. All fevers in children less than 2 months of age must be reported immediately. Do not give any medication to this age group unless you have first consulted your physician.

HEAD INJURY

Head injuries are common during childhood, and are seldom severe. There are a variety of signs and symptoms to watch for following head trauma for the first 48 hours.

Check your child every two hours for the first 24 hours following a serious head injury, and call your physician or take the child to the nearest emergency room if any of the following signs or symptoms develop:

1. Excessive drowsiness. Many children are drowsy and nap following the excitement of a head injury, but they should be arousable using the usual means to awaken them from sleep.
2. Persistent vomiting. Many children will vomit once or twice immediately after a head injury. Persistent vomiting, or vomiting beginning more than two hours after the injury needs to be evaluated.
3. Vision or eye problems. Abnormal findings include: pupils which are not the same size, are small in the dark or large in bright light, peculiar eye movements, difficulty in focusing, or other apparent vision changes.
4. Speech which becomes slurred or inability to speak.
5. Inability to move arm(s) or leg(s), numbness, weakness, stumbling or peculiar walking.
6. Excessive headache. Headache is common after head injury, and your child may have an appropriate dose of acetaminophen. Headache which persists or becomes increasingly severe needs to be evaluated.
7. Unusual restlessness, persistent confusion, memory loss, loss of consciousness, or convulsions.

IMMUNIZATIONS

Immunizations are an important means of preventing serious childhood diseases, and all states have requirements for immunization prior to school admission. Our physicians are strong advocates of immunizing every child, and many will not see children whose parents refuse immunization. Those who do may require you to sign a document acknowledging the danger in which you place your child. Our resolve that immunizations are beneficial and necessary can not be overstated.

Pediatrics East follows the *American Academy of Pediatrics* guidelines when administering immunizations. The current guidelines are formulated into a schedule, which appears at the end of this book, conveniently next to pages for you to record information regarding each of your child's checkups. There are occasional shortages of various vaccines, but we make adjustments to insure your child remains up to date and properly protected. If there are changes to the vaccine schedule your doctor will make you aware of them, and make sure your child is fully protected.

We stress the importance of parents keeping their own up-to-date record of their child's immunizations. The immunization record will be necessary many times throughout childhood, adolescence and even in adulthood, as most high schools and colleges now require proof of immunizations for admission. Our nurses will be happy to provide you with a form on which all of your child's immunizations will be documented and will update this form each time a new immunization is given. Please bring this form to every well child examination. At the completion of your child's immunizations series, store this record with your child's birth certificate and other important papers.

If you get your child's immunizations at the Health Department, please bring the record with you at your next appointment so that we can update our records. We will not be able to complete school, scouting, or sport forms without written proof of immunization.

Immunizations can be given on an out-patient basis in our offices only if the child has had a recent check-up (usually within the last 12 months). We also ask that you have a written order from your physician for out patient shots and that you go to the office where your chart is located. This is done to insure your child's immunizations are recorded correctly.

IMPETIGO

Impetigo is a superficial infection of the skin. It is most often seen during the summer months as shallow crusting or weeping sores, usually on the arms or legs, but sometimes on the face as well. Impetigo usually results from a *Staph* or *Strep* infection introduced into the skin by scratching cuts or insect bites. Treatment of impetigo consists of:

1. Daily washing of "sores" with soap and water.
2. Keeping fingernails clean and short.

3. Having your child use his own wash cloth and towel while sores are healing.
4. Application of a prescription antibiotic ointment to sores in mild cases.
5. A course of oral antibiotics in more severe cases.

Return to the office if the sores are not improving in 5 days, sooner if the sores spread to other areas of the body or if redness or swelling develops around the sores.

LICE

Lice are tiny insects that lay their eggs on the hair shaft near the scalp, and are a very common problem in children. Treatment includes use of a medicated shampoo called Nix, which may be purchased over-the-counter, followed by careful inspection and cleaning of the scalp. Follow the directions on the bottle. Wash all bed cloths and clothing that the child has used in the previous 48 hours in hot water. Discard combs and brushes. Check other family members for infestation as well, and treat them accordingly.

NOSEBLEEDS

Nosebleeds are common in children when the air is dry. Winter time nosebleeds can often be reduced by running a humidifier in the home. The best way to treat a nosebleed is:

1. Have your child lean forward so that blood does not run down the throat.
2. Pinch the nostrils between thumb and index finger for 5 minutes continuously.
3. Have child blow nose lightly and repeat step 2 if bleeding continues.
4. After a few hours apply a dab of Vaseline to the area inside the nostrils.

OTITIS EXTERNA (SWIMMER'S EAR)

This is an infection of the ear canal (between the outer ear and ear drum). It is most common during the summer months, and is often associated with swimming. Since the infection is limited to the canal, the treatment consists of antibiotic ear drops placed in the ear. If your child complains of an ear ache, give him/her Tylenol or Motrin, and make an appointment to see the doctor as soon as possible.

Swimmer's Ear can be prevented in children with normal ear drums and no P.E. tubes by putting a few drops of an equal mixture of rubbing alcohol and white vinegar in the ear after swimming.

OTITIS MEDIA (MIDDLE EAR INFECTION)

Otitis media is infection behind the eardrum. It most commonly occurs in children under age 6 and usually follows a cold or sore throat. Infants and toddlers

frequently pull at their ears in response to this infection, but pulling ears is not a 100% reliable sign on its own.

An antibiotic is often prescribed to treat an ear infection. It is important to always take the ENTIRE PRESCRIPTION. Generally it is not necessary to have the ears rechecked; however if chronic infections are a problem your doctor may recommend having your child's ears rechecked 10 to 14 days afterwards to assure the infection completely resolves.

Some parents believe that water in the ear canal can cause otitis media. Water can't get into the middle ear through the ear canal unless there is a hole (like PE tubes) in the ear drum.

PHARYNGITIS (SORE THROAT)

Pharyngitis can result from viral or bacterial infection (i.e. strep throat), or simply may be due to sinus drainage. During the winter months, your child may complain of a sore throat every few weeks. Viral and strep infections are often very similar, and may include sore throat, headache, difficulty swallowing, cough, vomiting, stomach ache, fever or rash. If your child has several of these symptoms and they persist for a few days, your child's doctor will want to do a rapid strep test or overnight throat culture.

Almost 85% of all sore throats are viral in origin. These will not improve by taking antibiotics. If your child does have strep throat, he/she will require either a full course of antibiotics by mouth or by an injection, and will remain contagious for between 24 and 48 hours. Never share a child's antibiotic with sister/brother if they develop similar symptoms. We should evaluate the need for an antibiotic in each child.

Some things to do to help a child with a sore throat feel more comfortable:

1. Chloraseptic spray or throat lozenges in appropriately aged children.
2. Encourage them to drink plenty of cold fluids.
3. Treat their discomfort with acetaminophen.

PINWORMS

Pinworms look like tiny white threads and live in the large intestine. At night they travel to the anus and lay nearly invisible eggs on the outside skin. This makes the skin itch and often cause restless sleep and rectal scratching. Since the infection is spread by passage of eggs from finger to mouth, other family members are also at risk by accidental transmission through handling pajamas, underwear, a towel or other object. Pinworm treatment requires oral medication, and your doctor may recommend all family members be treated when infection is identified. Frequent hand washing, keeping nails clean, and washing underwear and bed linens in hot water are important control measures.

RINGWORM

Ringworm is a fungal infection of the skin, usually having ring-shaped sores with raised and sometimes scaly edges. The center of the ring usually remains clear. It is treated with a 2 – 4 week course of antifungal medication, such as Lotrimin AF or Tinactin (available without prescription). Make an appointment if there is no sign of improvement in 2 weeks. Other family members should be checked for the rash as well.

Fungal infection between the toes is commonly termed “Athlete’s Foot.” Treatment includes medicated powder, spray or ointment, such as Desenex or Tinactin or Micatin. There are less expensive, equally effective store brands available for each. Check the labels. Keep the feet as clean and dry as possible, and use cotton socks. Come to the office if blisters develop, or if there is no sign of improvement in 2 weeks. The shower floor makes an excellent way for family members to share this infection.

Fungal infection of the scalp may cause flaking or bumps on the scalp, and even hair loss. Treatment requires a prescription taken by mouth for 1 – 2 months. Make an appointment if the affected area becomes red, swollen, or if sores develop.

SCABIES

Scabies is a very itchy red rash caused by a small insect that burrows into the skin. It is spread by close contact with other infected persons. Treatment consists of:

1. Warm bath at bedtime and drying completely, then
2. Applying the recommended lotion to all parts of the body from the neck down, especially under the arms, between the fingers and toes, and in the genital area. (If your child is a thumb-sucker, cover his hands with a sock or other wrap after the lotion is applied.)
3. Thoroughly rinse the entire body in the morning.
4. Some medications require a second application the next night.
5. Thoroughly wash all clothing and bed linen in hot water.
6. Give Benadryl by mouth for itching.

Even after adequate treatment, the rash and itching may persist for weeks. Do not over treat. See your doctor if there is no improvement in 2 weeks.

SEIZURES AND FEBRILE SEIZURES (SEIZURES CAUSED BY FEVER)

Seizures (or “fits” or “convulsions”) can occur at any age. If your child has a seizure, stay calm and remove him or her from any danger. Do not attempt to force open their mouth or put anything between their teeth, and do not offer them anything to drink. Every child must be evaluated by a physician immediately after their first seizure.

Seizures caused by fever are most common in children from 6 months to 6 years of age. While they are frightening for the parents, they do not cause any harm to the child. See the section on fever for more information.

SLEEP

Sleep patterns, habits and the need for sleep vary between individuals and change with age. Most newborns sleep 20 or more hours per day in the first two weeks of life. Thereafter they usually sleep 12 – 16 hours per day throughout the first year of life. Since your baby will come home from the hospital without a set day/night schedule, it is important to encourage your child's waking during the day and avoid stimulation at night. The key word is stimulation. Most babies respond to talking, touching, rocking, etc. by trying to stay awake. During daytime feedings you should maximize stimulation of your newborn. At night limit stimulation as much as possible. Most babies can sleep through the night by 4 months of age.

We recommend that babies sleep in their own cribs or beds, in a room separate from parents. Newborns should be placed on their backs to sleep.

Babies should be placed in their cribs or beds while they are still awake, so they can learn to calm themselves to sleep. If they then wake in the night, they can get themselves back to sleep. The use of a transitional object, such as a blanket or stuffed animal, may help. A night light may also be beneficial.

Even when the above is done properly, sleep problems frequently develop late in the first year of life. These problems manifest by waking and crying out. If this occurs, check on your child with as little stimulation as possible (gentle words and patting). Reassure them that you will be nearby, but you expect them to go back to sleep. You may recheck them every 5 to 15 minutes, but only with minimal stimulation. We do not recommend that the child be fed, rocked, or taken to the parents room, as this reinforces waking and aggravates the problem. Of course a soiled diaper should be changed.

After the first year of life, family schedules will affect sleep habits. Some families go to bed and rise early, while others arrive home late and spend later nights together. Prior to bedtime it is better not to engage in rough play, exciting TV, etc., but rather spend time in quiet, calming activities. Warm baths, light snacks, brushing of teeth and bedtime stories will help relax your children. As they grow older, bedtime becomes an excellent time to listen to what your child has to say. All parents should take time, each day and uninterrupted, just to listen to their children.

Teenagers require more sleep than children aged 5 – 12. Do not be surprised if your adolescent requires more sleep, and is tired when he stays up late. Be prepared to enforce bed times if necessary during the adolescent growth spurt.

TEETHING

Most children's first teeth arrive some time between 2 months and one year old (the average is 7 months). Infants react differently to teething: some are fussy

and irritable, and some have a little diarrhea or a runny nose. A high fever is not a normal symptom of teething. The best treatment for teething is to give your child a cold pacifier or teething ring to bite on, or a rough washcloth soaked in ice water. Massaging the gums with your fingers may help. Tylenol may also be given.

THRUSH

Thrush is a yeast infection of the mouth, and commonly seen in infants. The first symptom may be reluctance to feed. You will see patchy white spots on the baby's lips, tongue, gums, roof of the mouth, or inside the cheeks. The white patches may look like milk but fail to scrape off easily. If you see this, contact your doctor for appropriate treatment.

THUMB SUCKING AND PACIFIERS

Sucking is a normal and essential function in infants. It is how they eat and a way for them to pacify, occupy, and comfort themselves. Thumb sucking and pacifier use in infancy need not be discouraged.

We do not recommend using pacifiers with breast-fed babies until they are accustomed to nursing and have a good latch. There is some evidence that pacifier use in babies over 6 months of age is associated with more frequent ear infections. We recommend that pacifier use stop between 12 to 15 months of age.

VOMITING

When children are vomiting, the stomach and intestinal tract must be put to rest. After a vomiting episode, nothing should be given by mouth for 1/2 to 2 hours.

Breast milk is considered a clear liquid, and may be offered via small (short), frequent feedings. At times a commercial oral electrolyte solution (Pedialyte, Infalyte, or Gerber) may be necessary in small quantities until the child feels like nursing again.

In bottle fed or older children you may offer a small amount (1 tablespoon) of oral electrolyte solution (for infants) or other clear liquids (for older children). You should wait 15 to 20 minutes to see if this is tolerated, then repeat every 5 – 10 minutes. Increase the volume slowly as tolerated. Solid foods may be added after 12 hours of no vomiting. If vomiting and diarrhea occur simultaneously, treat the vomiting first and then deal with the diarrhea.

Oral electrolyte solutions such as Pedialyte, Gerber electrolyte, Infalyte and Pedialyte frozen pops are usually well accepted by young children. If not, the taste can be improved by adding 1/4 teaspoon of Pre-Sweetened Sugar Free Kool-Aid to 8 ounces of solution. If you use unsweetened Kool-Aid, add 1/8 teaspoon of the Kool-Aid and either 2 packages of Equal or 1 package of Sweet'N'Low to 8 ounces of solution.

You should call the office if the vomiting does not resolve after 24 hours, or the vomiting is accompanied by severe abdominal pain or distension. You

should also call if there is bloody or black material in the vomitus, or if you are concerned about dehydration. Signs of dehydration include no urine production for 12 hours, sunken eyes, decreased tears, or sunken soft spot in an infant. You can also test for dehydration by gently pressing your child's fingernail and watching for the return of color. If the color returns in less than 2 seconds, your child is probably not seriously dehydrated.

Depending on your child's age and weight, an anti-vomiting medication may be prescribed.

SELECTED SAFETY TOPICS

ACCIDENT PREVENTION

Accidents are the leading cause of death in children over age 1. Many "accidents" can be prevented by anticipating danger and keeping your child away from dangerous situations.

ANIMAL SAFETY

Most animal bites are caused by dogs. Large dogs bite children more often than small dogs, and most animals which bite children are neighborhood or family pets. A stray animal is only rarely the culprit. Even the gentlest family pet may bite a child if frightened, injured, sick, or pestered while eating. Children should be taught not to disturb an animal that is sleeping or eating. Do not allow your child to hold his face directly next to an animal's face.

Teach your children how to protect themselves from animals. Tell them not to attempt to break up a fight between animals, even if the family's pet is involved. Tell them to stay away from strange animals. If they are approached by a strange dog, teach them to stand still, face the animal, talk quietly to him, and then back away slowly. Do not make any sudden moves and pivot slowly if the dog tries to get behind them. Teach them to protect their neck and face with crossed arms if attacked. If they are chased while on a bicycle and cannot get away from the dog, they should dismount and place the bicycle between them and the dog.

BICYCLE SAFETY

Safe bicycle riding begins with purchase of a correctly sized bike for your child. While sitting on the seat with hands on the handlebars, your child must be able to place the balls of both feet on the ground. (The seat should be no higher than the hips.) While straddling the center bar, there should be 1" of clearance between crotch and bar with both feet flat on the ground. Be sure your child has adequate hand strength to stop the bike if you plan to purchase one with only hand brakes. Take your child with you when choosing a bicycle, to assure a proper fit.

BY TENNESSEE LAW, A BICYCLE HELMET IS REQUIRED TO BE WORN EACH TIME YOUR CHILD RIDES A BICYCLE. You should insist your child wear a helmet each time he or she rides the bike. Choose only helmets that

carry the American National Standards Institute (ANSI) or Snell seal of approval. Be an example by wearing one yourself when biking with your child!

Make sure that your child knows rules of traffic safety: how to ride with traffic, stop and look both ways before entering the street, use hand signals when turning, and obey traffic signals. Do not allow him to ride double. Take bicycle privileges away for a few days if you observe unsafe behavior.

Make sure that the bicycle is in good repair. Check brakes and tire inflation regularly.

BURNS

A common place for burns to occur is in the kitchen. Do not allow your child to play underfoot in the kitchen while you are cooking. Keep pot handles turned inward while cooking. Do not attempt to drink a hot drink while holding a child. Children can move unexpectedly or grab the cup in an instant, and pour the contents on themselves (or on you!). Children also get burned on fireplaces, wood stoves, radiators, furnaces, outdoor grills and hair curlers. Be sure that your house hot water heater is set no greater than 125 degrees to prevent accidental burns at bath time.

If your child does get burned, place the burned part in cold water and call your doctor immediately. Do not apply butter or ointments until your child has been examined.

DROWNING

Water can be a source of tragic accidents in childhood. Never leave a small child or infant unattended in the tub or in an outdoor wading pool, or even with a bucket containing water. Home swimming pools should be surrounded by at least a 6 foot fence and locking gates. In households with small children, there should be an additional barrier (double fence) to keep unattended children away from the pool. Have rescue equipment available at poolside, including a safety ring buoy. All children must have parental supervision when swimming in a pool. (Keep in mind that babysitters and grandparents are not always as attentive as you might be.) Do not assume that a preschool child is safe in the water even if he or she has had swimming lessons. Any child who is treated for near-drowning requires immediate transport to an emergency room.

One additional water hazard occurs as children become adolescents. As they get bigger, their dives take them deeper into the water. Teach them to always check the depth of the water they are diving into. This includes the deep ends of home swimming pools.

FIRE SAFETY

Protection of your family and house from fires requires planning ahead. Do not leave small children alone in the home, even for a few minutes. Install fire and smoke detectors on each level of your house, check them monthly, and replace the batteries every 6 months. Teach your child what the smoke detector alarm sounds like, and how to respond to its sound. Plan escape routes from various

parts of the house and decide where to meet outside. Practice family fire drills twice a year. Since many residential fires happen at night, hold some of these family fire drills at night. Teach children how to crawl out of the house, to protect them from smoke inhalation, and how to check closed doors for heat. There should be rope or chain ladders stored on each floor above ground level, in case stairs are blocked by fire.

You can minimize your risk of an accidental house fire. Keep matches and lighters out of reach of children. Do not smoke in bed and dispose of all smoking materials carefully. Be careful with portable heaters. Protect your children from fireplaces and wood stoves. Have your heating system inspected and cleaned annually. Check to be sure that your electrical wiring is in good condition, and that circuits are not over loaded. Use properly sized fuses or circuit breakers, and never use a substitute (such as a penny) for a fuse. Have at least one fire extinguisher in the home and know how to use it.

If you do have a fire, get everyone out of the house **immediately**. (Most deaths in residential fires occur from suffocation and smoke inhalation, not from the flames.) As you escape from a burning house, place your hand on the door before you open it. You may need to crawl as you escape if smoke is present. Call the fire department from a neighbors' house. **Do not re-enter a burning building, even for family treasures or the family pet!**

INSECT STINGS AND BITES

1. Bee and Yellow Jackets stings:

Over 95% of insect stings are from yellow jackets. 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. A sting on the tongue can cause swelling that interferes with breathing.

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 don't worry about it. Then rub each sting for 20 minutes with a cotton ball soaked in a meat tenderizer solution. This will neutralize the venom and relieve the pain. For persistent pain, massage with an ice cube for 10 minutes. Give acetaminophen or ibuprofen immediately for relief of pain and burning.

Call 911 if:

- Breathing or swallowing is difficult
- Your child starts acting very sick

Call during regular office hours if:

- Hives are present without breathing or swallowing difficulty
- There are 10 or more stings
- Swelling of the hand (or foot) spreads past the wrist (or ankle)
- You have other questions or concerns

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 1/2 inch. A larger size welt 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 mosquitoes: itchiness, a central raised dot in the swelling, bites on surfaces not covered by clothing, larger welts on younger children.

In contrast to mosquitoes, fleas and bedbugs don't fly; 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 ants bites change to blisters or pimples.

Treatment: Itchy insect bites—Apply calamine lotion or a baking soda paste to the area of the bite. If the itch is severe (as with chiggers), apply nonprescription 1% hydrocortisone cream 4 times daily. 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 for 20 minutes. This will relieve the pain. If you don't have any meat tenderizer, use a baking soda solution. Give acetaminophen or ibuprofen for pain relief.

Call immediately if:

- The bite looks infected (yellow pus, spreading, redness, red streaks).

Call during regular business hours if:

- Itching or pain is severe after treatment.
- You have other questions or concerns.

Insect Repellents must be used with caution, especially those containing DEET (N, N-diethyl-m-toluamide). DEET can be absorbed across the skin into the bloodstream, and products with high concentrations may 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:

- Use DEET products formulated for children. These contain 10% or less DEET. Even adults don't need more than 30% DEET, as studies have shown no improved repellent action with higher concentrations.
- 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 to 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 your child comes indoors.

3. Tick bites:

A tick is a small brown bug that attaches itself 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 1/2 inch in size. The deer tick, which transmits Lyme disease, is the size of a pin-head.

Treatment: The simplest and quickest way to remove a wood tick is to pull it off. Use a pair of 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 tweezers aren't available, use fingers, a loop of thread around the tick's jaws, or a needle between the jaws for traction. Tiny deer 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). Apply antibiotic to the bite at once. Wash the wound and your hands with soap and water after removal.

(A recent study showed embedded ticks do not back out with the application of a hot match or when covered with petroleum jelly; fingernail polish, or rubbing alcohol. We formerly thought those products would block the tick's breathing pores and take its mind off eating. Unfortunately; ticks breathe only a few times per hour.)

Prevention: When hiking in tick-infested areas you should wear long clothing and tuck the end of pants into the socks. Apply an insect repellent to shoes and socks (permethrin products are more effective than DEET products). Perform tick checks using a buddy system every 2 to 3 hours to remove ticks on clothing or exposed skin. A brisk shower will also remove any tick that isn't firmly attached. Favorite hiding places are in the hair, neck, armpit and groin. Removing ticks promptly may prevent infection because transmission of Lyme disease requires 18 to 24 hours of feeding. Ticks are easier to remove before they become firmly attached.

Call immediately if:

- You can't remove the tick
- A fever or rash occurs within the 2 weeks following the bite
- You child starts acting very sick

Call during regular office hours if:

- You think your child might have Lyme disease
- You have other questions or concerns

MOTOR VEHICLE ACCIDENTS

The most important factor in reducing motor vehicle injuries and fatalities is the use of infant and child car seats and safety belts. Since 2/3 of all traffic fatalities occur less than 25 miles from home, these safety devices must be used each time the child travels in a car or truck. Even the first ride home from the hospital after birth must be in an approved car seat.

We discourage the use of cell phones by drivers most strongly. This includes text messaging and all other distractions offered by electronic devices.

TENNESSEE'S CHILD RESTRAINT LAW—Effective July 1, 2004

- Children younger than age 1 or weighing 20 pounds or less must ride facing the rear in the back seat. (If your child is a 25 pound 9 month old, or a 17 pound 18 month old they must still ride facing rearwards.) If your rear-facing child safety seat has a weight limit, use it as long as your child's weight permits. Check the manufacturer's instructions.
- Children ages 1 through 3, and over 20 pounds, must ride in forward-facing child safety seats in the back seat.
- Children aged greater than 3 but less than 9, and less than 4 feet 9 inches tall, must ride in belt-positioning booster seats in the back seat. They must use both lap and shoulder belts.
- All children 9 years and older must buckle up in a properly positioned belt system.
- This is a primary offense. Police officers can stop cars just because someone is not properly restrained. They can give tickets with \$50 fines.

Do you need more information? Would you like to make an appointment to safely install child safety seats?

Call the Mid-South SAFE KIDS coalition, headquartered at LeBonheur Children's Medical Center, at (901) 287-6730

Among children under 15 years of age, fatal injuries as pedestrians are more common than as vehicle occupants. The majority of pedestrian deaths occur to children crossing the street, with more than half of these accidents occurring between intersections. Teach your child to cross the street at intersections after looking both ways.

PLAYGROUND SAFETY

Each year more than 200,000 children in America require emergency room visits for injuries sustained while playing on playground equipment. About half of these injuries occur on playground equipment at home, and about half occur at public facilities. Swings and swing sets account for the largest number of injuries, with climbing equipment involved next most often. The majority of the injuries are caused by falls.

Playground equipment should be placed at least six feet away from fences, buildings, walls or walkways. The equipment should be properly assembled and anchored. The anchors should be below ground surface and should not be exposed. Platforms should have guard rails, and should be no more than six feet off the ground. Exposed bolts and nuts should be capped. Sharp edges should be rounded or taped for protection. Rings over 5", but less than 10" in diameter, can entrap a child's head and should be permanently removed. Hooks used to attach swings should be pinched closed to avoid catching skin or clothing. Choose light-weight swing seats rather than heavy, hard seats.

Proper maintenance of playground equipment is an important factor in reducing injuries. All equipment should be inspected every other week. Look for weak hangers or chains, loose bolts or screws, frayed ropes, worn moving parts, or splinters. Replace missing hardware.

A large number of injuries on playground equipment involve falls injuring the head and neck area. The equipment should be surrounded by an impact-absorbing surface, such as sawdust, wood chips, sand, or shredded rubber. During your safety check every other week, be sure that adequate impact-absorbing surface material remains under the equipment.

POISONING

Children under the age of 5 are the most frequent victims of poisoning, with children 1 to 3 being at highest risk. Even as early as 4 – 6 months of age, most infants are rolling over and are increasing their activity daily. This is also the age that babies examine most objects by placing them in their mouth. Toys should not have removable parts that can be swallowed. Parents should make a walking tour of their home, removing small objects (smaller than a 50-cent piece) from the floors, tables, and other accessible areas. This is also the time to begin safety plugging all electrical outlets, and placing safety catches on kitchen and bathroom cabinets.

Keep all medication and household products out of reach of children. Remember that even a child as young as 6 months old can reach floor-level cabinets. By 9 or 10 months some children can reach table tops, counters and drawers. When they are old enough to climb stairs and chairs, they can reach upper level cabinets in the house and garage. By that point, your whole house must be poison proofed. Be extra careful whenever you visit a home that may have medications or household products within reach of your children. Over a third of all prescription medicine belongs to grandparents.

It is preferable to keep medication in a locked storage area. Never call medicine "candy." Do not take medicine yourself in the presence of young children, as they may try to copy your behavior with your medicine. Teach your children not to drink or eat any substance unless an adult gives it to them. Always double check medicine labels before administering medication to your children.

Keep products in their original containers. Do not put inedible products in food containers, such as mineral spirits in a Coke bottle, or in unmarked containers.

Do not store food and non-food items such as cleaning products together. Do not leave your child unattended with a product that you are using (for example, take the product or the child with you when you answer the phone). Buy your medicines and household products in childproof containers when possible. Do not use solid rat or insect poison on floors or in cabinets. Do not purchase poisonous houseplants while you have young children at home. Periodically go through your home and discard outdated medicines and home remedies.

Consider the places your child visits which may contain poisons, including medicines. Grandparents will more frequently have easy open bottles for their medicines; and under the sink, the laundry, garage, and tool shed may not be as safe for your child as they are at home. Gently approach those who care for your child, asking them to child-safe their house as well, for the child's sake.

If you suspect your child has taken any toxic or poisonous agents by mouth, you should immediately call the National Poison Hotline at (800) 222-1222.

WALKERS

The majority of baby walkers are used by children ages 6 – 12 months old. 30 – 40% of children who use walkers will have an accident. Most of these accidents are minor. However, serious injuries can occur, including closed head trauma, fractures, lacerations, tooth avulsions, contusions and pinched fingers. The most serious injuries occur from falling down stairs.

Most walker injuries occur at home with one or both parents present. The risk of injury is directly related to the amount of time spent in the walker, with over 1/2 of the children who spend more than 2 hours per day in the walker being injured.

Many parents buy walkers to stimulate ambulation in their children. However, there is no evidence that walkers help babies learn to walk sooner than they otherwise would. In fact, in twin studies, the “non walker” twin walked earlier than the “walker” twin. The type of leg motion stimulated by walkers is different from that found with non-assisted walking.

Because of the high risk of injury, and the documented lack of benefit from the use of a walker, the physicians of Pediatrics East recommend that you not use a walker with your child.

XYZ

Other suggestions regarding accident prevention:

1. Never feed small children nuts, popcorn or small hard candies. Be careful when feeding your child hot dogs. Do not allow children to eat while walking or running.
2. Keep knives, scissors, needles, pins, forks, matches, lighters, and guns out of reach of children. Guns should be disabled and secured when not in use. No gun should ever be stored loaded.
3. Plastic bags, large balloons, and similar objects can suffocate or choke children.

CHECK-UP SCHEDULE	IMMUNIZATIONS OR LAB WORK	DATE
2 Week Check-up		_____
2 Month Check-up	DTaP #1/IPV #1/Hib #1/Hep B #1 Pevnar #1/RotaTeq #1	_____
4 Month Check-up	DTaP #2/IPV #2/Hib #2/Hep B #2 Pevnar #2/RotaTeq #2 (Cannot start the RotaTeq now)	_____
6 Month Check-up	DTaP #3/Pevnar #3/RotaTeq #3 (Cannot start the RotaTeq now)	_____
9 Month Check-up	No Immunizations	
12 Month Check-up	IPV #3/Pevnar #4/Hep A #1 Hematocrit	_____
15 Month Check-up	DTaP #4/Hib #3/Hep B #3/MMR #1	_____
18 Month Check-up	Hep A #2/Varivax #1	_____
2 Year Check-up	Hematocrit	_____
3 Year Check-up	Hematocrit/UA	_____
4 Year Check-up	Hematocrit/UA	_____
5 Year Check-up	DTaP #5/IPV #4/MMR #2 Varivax #2//Hematocrit/UA	_____
Annual Check-ups	Lab Work, Catch up shots	_____
11 – 12 year Check-up	Tdap/Menactra/Gardasil#1(females) Hematocrit/UA	_____
11 – 12 years + 2 mo.	Gardasil #2	_____
11 – 12 years + 4 mo.	Gardasil #3	_____
Check-ups every 2 years thereafter	Lab Work, Catch up shots	_____

VACCINE NAME	DESCRIPTION
DTaP	Diphtheria, Tetanus, & acellular Pertussis (whooping cough)
IPV	Inactivated Polio Virus
Hep B	Hepatitis B vaccine
Hib	<i>Haemophilus Influenza</i> (meningitis)
Comvax	Hepatitis B & <i>Haemophilus Influenza</i> vaccines
Prenvar	<i>Strep Pneumonia</i> (meningitis/pneumonia/otitis media)
RotaTeq	Rotavirus gastroenteritis (infants) oral vaccine
Hep A	Hepatitis A vaccine
MMR	Measles, Mumps & Rubella vaccines
MMRV	Measles, Mumps, Rubella & Varicella (Chicken Pox)
Varivax	Chicken Pox Vaccine
Menactra	<i>Neisseria meningitis</i> vaccine
Tdap	(Adacel) Tetanus, Diphtheria & Pertussis (children >11 and adults)
Gardasil	Human Papilloma Virus
PPD	Purified Protein Derivative (TB test)

ROUTINE WELL CARE SCHEDULE

2 WEEKS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

4 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

9 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

2 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

6 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

12 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

ROUTINE WELL CARE SCHEDULE (CONT'D)

15 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

18 MONTHS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

2 YEARS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

3 YEARS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

4 YEARS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

5 YEARS

DATE:

AGE:

HT:

WT:

HC:

Comments:

Next Visit:

and Semi-Annually or Annually thereafter as recommended by your doctor