



*From Birth through Adolescence*

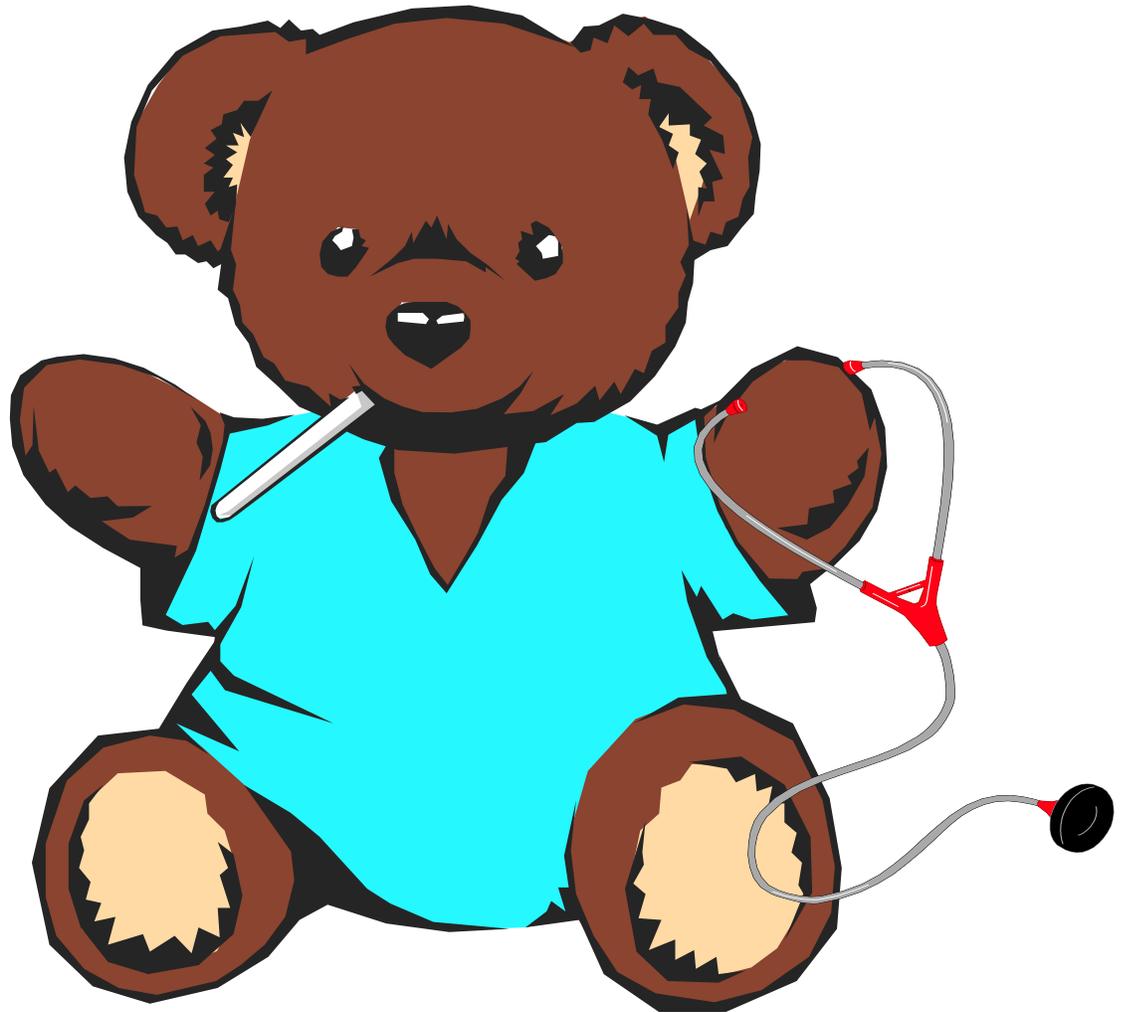
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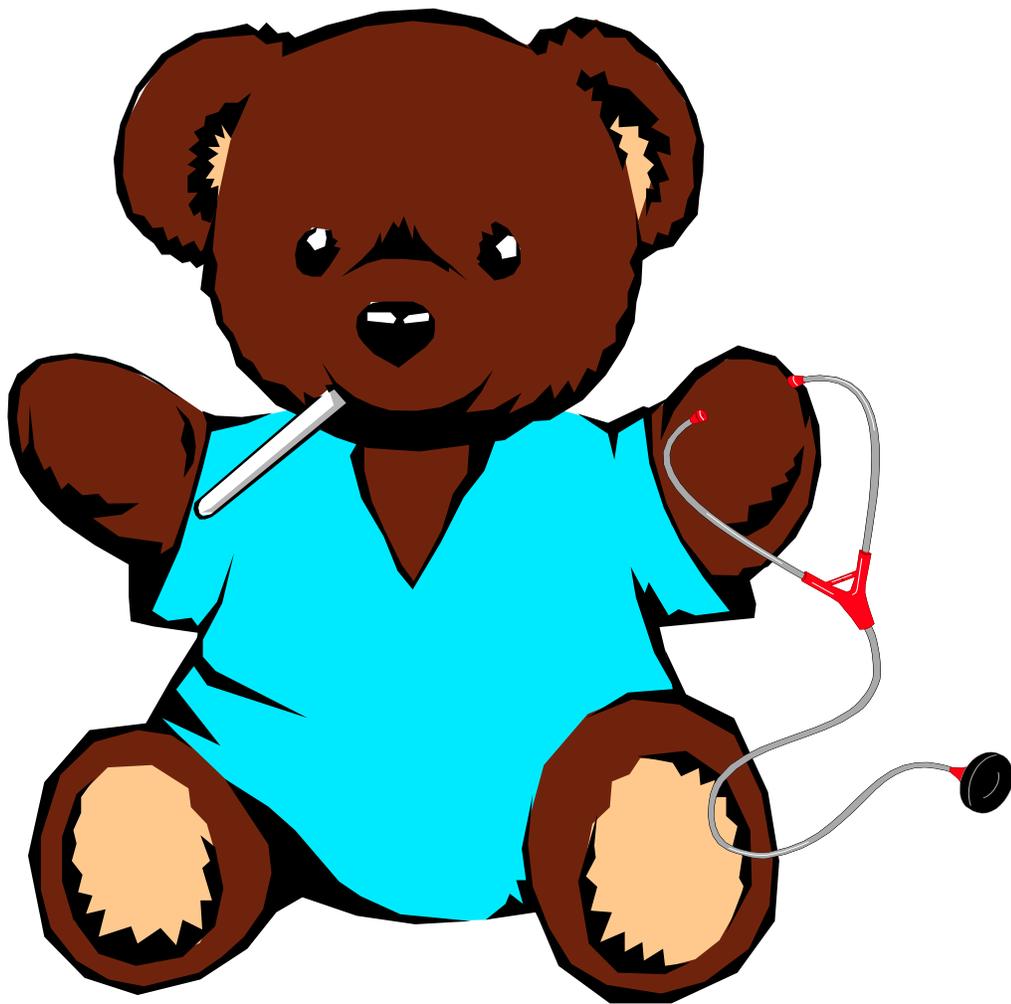
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# PARENTS MEDICAL HANDBOOK

## A Guide to Common Pediatric Problems



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# PARENTS MEDICAL HANDBOOK

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## INTRODUCTION

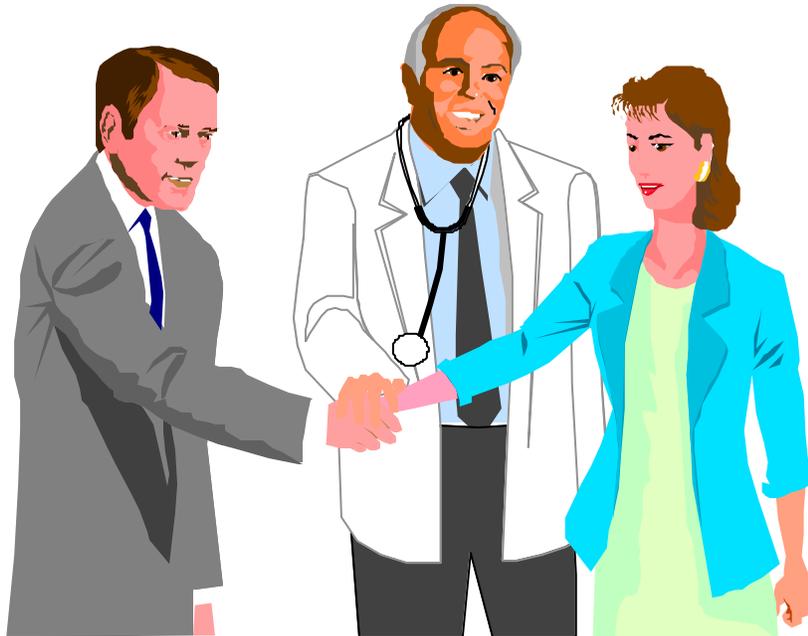
This manual was designed to provide parents with a brief, practical overview of common childhood medical problems. It is not intended to substitute for the advice of your physician, but may save unnecessary worry or confusion regarding many pediatric medical issues. We recommend you keep this booklet handy for the next few years. Your doctor's office may refer you to it from time to time.

The first topics presented are the periodic wellness visit and immunization schedules recommended by the American Academy of Pediatrics and the American Academy of Family Practice. Wellness visits provide an opportunity for your child's physician to observe physical changes, detect problems, review growth and development, and to address your concerns and questions.

The remainder of this manual consists of medical topics and treatments, listed alphabetically and followed by a dosage chart for common medicines and a suggested reading list for parents. The materials presented here have been endorsed by the primary care physicians of SHARP, Inc. We hope they are helpful to you.

**Handbook revised 8/2011**

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**FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])**

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B <sup>1</sup>	Hep B	HepB	HepB			HepB		HepB						Range of recommended ages for all children
Rotavirus <sup>2</sup>			RV	RV	RV <sup>2</sup>									
Diphtheria, tetanus, pertussis <sup>3</sup>			DTaP	DTaP	DTaP	DTaP	see footnote <sup>1</sup>	DTaP					DTaP	
Haemophilus influenzae type b <sup>4</sup>			Hib	Hib	Hib <sup>4</sup>			Hib						Range of recommended ages for certain high-risk groups
Pneumococcal <sup>5</sup>			PCV	PCV	PCV			PCV				PPSV		
Inactivated poliovirus <sup>6</sup>			IPV	IPV				IPV					IPV	
Influenza <sup>7</sup>								Influenza (Yearly)						
Measles, mumps, rubella <sup>8</sup>								MMR		see footnote <sup>1</sup>			MMR	
Varicella <sup>9</sup>								Varicella		see footnote <sup>1</sup>			Varicella	Range of recommended ages for all children and certain high-risk groups
Hepatitis A <sup>10</sup>								Dose 1 <sup>10</sup>				HepA Series		
Meningococcal <sup>11</sup>								MCV4 — see footnote <sup>11</sup>						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Hepatitis B (HepB) vaccine.** (Minimum age: birth)  
**At birth:**
  - Administer monovalent HepB vaccine to all newborns before hospital discharge.
  - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after receiving the last dose of the series.
  - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing  $\geq 2,000$  grams, and HepB vaccine plus HBIG for infants weighing  $< 2,000$  grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing  $\geq 2,000$  grams (no later than age 1 week).**Doses after the birth dose:**
  - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
  - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
  - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
  - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
- Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])
  - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
  - If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
  - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Haemophilus influenzae type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
  - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
  - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
- Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
  - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
  - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
    - All children aged 14 through 59 months
    - Children aged 60 through 71 months with underlying medical conditions.
  - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/r1111.pdf>.
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
  - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
  - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
- Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
  - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/r0808.pdf>.
  - For children aged 6 months through 8 years:
    - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
    - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
  - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
  - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
- Varicella (VAR) vaccine.** (Minimum age: 12 months)
  - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
  - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
  - Administer the second (final) dose 6 to 18 months after the first.
  - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2008;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/r0707.pdf>.
  - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])
  - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
  - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
  - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
  - See *MMWR* 2011;60:72–8, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, and *MMWR* 2011;60:1391–2, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf>, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).  
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**FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])**

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, diphtheria, pertussis <sup>1</sup>		1 dose (if indicated)	1 dose	1 dose (if indicated)	Range of recommended ages for all children
Human papillomavirus <sup>2</sup>		see footnote <sup>2</sup>	3 doses	Complete 3-dose series	
Meningococcal <sup>3</sup>		See footnote <sup>3</sup>	Dose 1	Booster at 16 years old	Range of recommended ages for catch-up immunization
Influenza <sup>4</sup>		Influenza (yearly)			
Pneumococcal <sup>5</sup>		See footnote <sup>5</sup>			Range of recommended ages for certain high-risk groups
Hepatitis A <sup>6</sup>		Complete 2-dose series			
Hepatitis B <sup>7</sup>		Complete 3-dose series			
Inactivated poliovirus <sup>8</sup>		Complete 3-dose series			
Measles, mumps, rubella <sup>9</sup>		Complete 2-dose series			
Varicella <sup>10</sup>		Complete 2-dose series			

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
  - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
  - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
  - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
  - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
  - The vaccine series can be started beginning at age 9 years.
  - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
  - See *MMWR* 2010;59:626–32, available at <http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf>.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).**
  - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
  - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
  - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
  - If the first dose is administered at age 16 years or older, a booster dose is not needed.
  - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
  - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
  - See *MMWR* 2011;60:72–76, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, for further guidelines.
- Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
  - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/mm5908.pdf>.
  - Administer 1 dose to persons aged 9 years and older.
- Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
  - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/mm5911.pdf>.
  - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
- Hepatitis A (HepA) vaccine.**
  - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/mm5507.pdf>.
  - Administer 2 doses at least 6 months apart to unvaccinated persons.
- Hepatitis B (HepB) vaccine.**
  - Administer the 3-dose series to those not previously vaccinated.
  - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
  - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
  - The final dose in the series should be administered at least 6 months after the previous dose.
  - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
  - IPV is not routinely recommended for U.S. residents aged 18 years or older.
- Measles, mumps, and rubella (MMR) vaccine.**
  - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
- Varicella (VAR) vaccine.**
  - For persons without evidence of immunity (see *MMWR* 2007;56(No. RR-4), available at <http://www.cdc.gov/mmwr/pdf/rr/mm5604.pdf>), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
  - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
  - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).  
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## ACCIDENT PREVENTION

### Newborn Infant

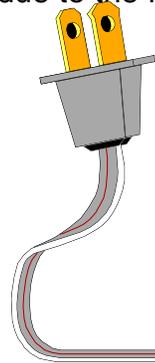
1. Child Car Safety Restraint: When your child leaves the hospital, his or her first ride must be a safe ride in a car seat. The car seat must be set in the rear facing position. A rear facing car seat must not be in a seat where the air bag may deploy. This is very dangerous. By the time a child is one year old, weighs 20 pounds and is sitting well unsupported, the car seat may be faced forward. According to the Arkansas Child Passenger Protection Act, which was approved February 28, 2001, a child should remain restrained in a child passenger safety seat until the child is approximately 60 pounds or about six years of age, then a safety belt is sufficient to meet the requirements of the law.
2. Crib Safety: Crib side rails should always be kept up when the infant is unattended. Crib bumpers are recommended. The distance between crib slats should be less than 2-3/8 inches. You should avoid toys and mobiles with long strings, cradle gyms that are not securely suspended and small objects in the crib. Do not place crib near a window with blinds.
3. Never leave your infant alone with young siblings or pets.
4. Your water heater thermostat should be set at 120 degrees Fahrenheit or less. This is a little below the normal setting.
5. Never leave your infant alone on a bed or other surface from which he/she may roll off.
6. Never leave your infant alone in a house or in a car unattended.
7. Do not shake or jiggle your baby's head vigorously.
8. Infant jewelry such as earrings, necklaces, rings or other types of jewelry are not recommended.
9. Do not drink hot liquids or smoke cigarettes while holding your child because you could burn your child.
10. Do not use an infant feeder to feed your child baby food or semi-solid food because of the risk of choking and aspiration of food into the trachea.



All infants should sleep on their back or side to lessen the risk of Sudden Infant Death Syndrome (SIDS).

## Young Infant (Six Months)

1. Small objects, baby powder and cleansers should be kept away from the baby so that he/she may not swallow these materials.
2. Small toys should be checked closely for the possibility of breakage and small loose parts that can be pulled off and swallowed.
3. The purchase of an infant walker is generally discouraged because of the risk of injury. If one is purchased anyway, constant supervision is recommended especially around stairs. **The use of an infant walker will not help your child walk alone at an earlier age.**
4. It is important to check your home for possible physical hazards such as balconies, stairs, fireplace hearths and sharp table edges. The child should be protected from these hazards by gates and padding as appropriate. Expandable gates should be checked for appropriate spacing due to the risk of strangulation.
5. A “crawling tour” of your home is recommended, looking for possible hazards that your infant can get into. Electrical outlets should have plugs placed; cabinet doors should have locks. Poisons, cleaning products, furniture polish and other toxic materials should be placed well out of the reach of an infant. Other possible hazards should be identified and secured.
6. Infants should be protected from the possibility of drowning in a swimming pool. In addition, an infant should **never be left alone in the bathtub.**
7. A playpen is suggested to be used as an “island of safety”; but, like the crib, safety precautions should be taken to avoid choking, strangling and suffocating hazards.



## Older Infant (9 to 12 months)

1. The incidence of accidental poisoning greatly increases by this age. Poisons and toxic substances should be secure. A bottle of Syrup of Ipecac should be kept in the home, but should only be used on the advice of a physician. In case of poisoning, refer to the poisoning section of this handbook. **For a poison emergency in the U.S. call 1-800-222-1222.**

2. If guns are kept in the home, safety precautions are crucial. Gun related injuries and deaths have become a major threat to our children. A loaded gun represents a huge hazard to a curious child or teen. The American Academy of Pediatrics urges parents to keep firearms unloaded, with ammunition and weapons locked away in separate locations.
3. Infants and children should not ride on machinery with parents. These include lawn tractors, lawn mowers, all-terrain vehicles and other like machinery.
4. Foods such as nuts, bacon, popcorn, chewing gum, hard candy, and hot dog like meats are dangerous because they can cause choking. They should never be given to young children.
5. Plastic bags and uninflated balloons can also cause choking and/or suffocation. Your young child should not be allowed to play with these.

### **Young Children (Over age 1)**

1. All outside play near the street or driveway should be strictly supervised. Be especially careful when backing out of the driveway.
2. Other measures concerning car safety, poisoning, drowning prevention and burn prevention, as mentioned before, all apply to this age group.

### **Preschool Child (3 to 5 years)**

1. According to the Arkansas Child Passenger Protection Act, which was approved February 28, 2001, a child should remain restrained in a child passenger safety seat until the child is approximately 60 pounds or about six years of age, then a safety belt is sufficient to meet the requirements of the law. **The rear seat is the safest place for a child to ride.**
2. Keep knives and other sharp objects out of reach.
3. Teach your child the danger of following a ball or an animal into the street, but **do not depend upon your child's remembering such instructions.**
4. Advise your child to be careful around strange dogs and other animals.
5. You may begin to teach your child to swim at this age. Even though your child may know how to swim, he/she is not watersafe at this age. Close supervision while swimming is a must.
6. Your child should be taught his/her name, parent's name, address and telephone number. Also, your child should be taught not to go with strangers or accept any food or candy from strangers.

7. Your child should be taught what to do in case of a fire in the home.

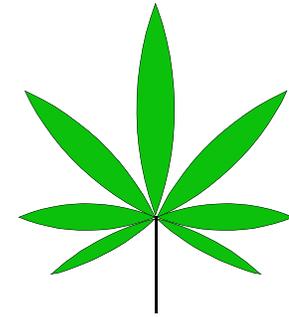


### Young School Aged Child

1. Your child should practice bicycle, skating and skateboard safety. A bicycle helmet is a must when riding bicycles, skating or skateboarding. Other safety approaches mentioned earlier still apply to this age.

### Teenage Years

1. Most serious accidents during the teenage years involve the mixture of automobiles and alcohol and/or drugs (such as, Marijuana: pictured at right). Motorized all-terrain vehicles and motorcycles are also very dangerous. Suicide and unwanted pregnancies are major health problems in adolescence. Sexual activity can result in venereal disease (including AIDS). Open, honest lines of communication between parent and child during this time of transition are extremely important to help teenagers avoid disastrous life-style choices. Withdrawal changes in behavior and/or friends should never be ignored. These may be warning signs that your teenager is undergoing stress. Parental involvement in a teenager's life can be a gratifying and helpful experience both for the teenager and the parent. **You should stay involved** in your child's life, especially during this time by keeping your communication lines wide open.
2. Teenagers who smoke become addicted faster than adults do and nicotine is as addictive as heroin, cocaine, and alcohol. Teenagers are more likely to smoke if friends, parents and older siblings smoke. Tobacco is the first substance used by those young people who use alcohol, marijuana, and other drugs. Smoking will cause lower level of lung function, reduced rate of lung growth, heart disease, faster resting heart rate, increased risk of lung cancer, and stroke, and smokers live approximately 7 years less than nonsmokers do. Smokeless tobacco will cause gum disease, cancer of the mouth, pharynx, esophagus and pancreas. **Start educating children early** about the risks and dangers of smoking before they are tempted to start. Starting smoking is easy; quitting smoking is extremely difficult at any age.



*Accident prevention for your child is a life-long endeavor. Common sense and effort go a long way to ensure that your child's life will be a long healthy one.*

## ALLERGIES & CHRONIC RESPIRATORY INFECTIONS

“Is my child allergic?” Allergy is a disease that tends to run in families. Allergic disorders have a wide variety of symptoms. They may cause symptoms as simple as a runny nose or they may result in a severe life-threatening event known as anaphylaxis. Of course, anaphylaxis is quite rare.

In the **very young infant**, allergy may be manifested by diarrhea, bloody diarrhea, nasal congestion, rash, wheezing and colic. These symptoms may be due to a formula allergy, which, if untreated, can be serious. Additionally, the same symptoms may not be due to allergy at all, but to an infection or other cause. Because of this, if your child exhibits the above symptoms, it is recommended that you contact your Physician for an appointment.

**Older infants and children** tend to have allergic manifestations that are very similar to what adults have. Food allergies can cause vomiting, diarrhea or blood in the stools. Conversely, some food allergies can cause nasal congestion, rashes, wheezing and/or anaphylaxis. Inhaled allergens may cause nasal congestion, runny nose or asthma. Airborne allergens can also cause watery, itchy eyes. The symptoms of allergy may mimic other diseases, especially infection. It is no wonder that there is a great deal of confusion about allergic disorders. Even physicians sometimes have difficulty sorting out allergic disorders from other problems.

If your child has any of the above symptoms or suffers from recurrent ear infections, sinus infections or if he seems to keep a cold all of the time, he/she may be showing signs of allergies. The simplest approach to stop allergic symptoms is to eliminate the suspected allergen from the environment or the diet. The following approaches may be helpful to the child with a chronic runny nose or a continual cold:

1. **AVOID CIGARETTE SMOKE:** More is being learned about passive smoking and its harmful effects on children. Children exposed to passive smoking are much more likely to suffer from ear infections, upper respiratory infections, sinus infections, bronchitis, pneumonia and other problems. If you must smoke, do this outside or in a well-ventilated room, completely away from the child. *It is recommended that you stop smoking for both you and your child's health.*
2. **AVOID EXPOSURE TO OTHER SICK CHILDREN:** This is especially a problem in daycare centers and with baby-sitters with large numbers of children. Try to place your child in a daycare situation that minimizes exposure to large numbers of children.
3. **AVOID HOUSE DUST:** Naturally, no one can avoid house dust completely, but strive to keep the child's bedroom as free of dust as possible.



- A. Enclose pillows and mattresses in plastic cases and wash these with a damp cloth two or three times per week.
- B. Take stuffed animals out of the room.
- C. Vacuum frequently.

#### 4. KEEP DOGS AND CATS OUT OF THE HOUSE.

5. **AVOID CERTAIN FOODS.** The most common food allergies are to milk, certain fish, eggs, strawberries and peanuts. Food elimination diets are best done under a physician's supervision.

Of course, medication allergies are important things to note in your child. If your child has an allergic reaction to a certain medication, you should always call your physician with the information. If your child has an allergic rash to an antibiotic for instance, a physician/nurse will usually like to examine the child to determine if the rash is consistent with allergy. In addition to this, you should keep a list of all medications to which your child is allergic and be sure to read labels. Many medications are marketed under several trademarks. For more information on antibiotic allergy see the section on antibiotics below. Remember that an allergic reaction can occur with a medicine, even if the child had the medicine previously without problems.

There are a number of medications which can reduce some of the symptoms of allergy. These include antihistamines, Cortisone type medications (steroids), and Cromolyn. Please consult your physician regarding proper use of these medications.



### ANTIBIOTICS

Antibiotics are medicines used to treat infections caused by bacteria. Most physicians are hesitant to prescribe antibiotics over the phone. Many types of illnesses do not benefit from antibiotics and may actually be made worse by taking them. Antibiotics are effective only against bacterial illnesses and have no effect on the course of viral illnesses such as the common cold, the flu and viral gastroenteritis (vomiting and diarrhea). An accurate diagnosis is essential to determine not only if your child needs an antibiotic, but also to decide which antibiotic will work best. **We therefore recommend that you make an appointment and have your child evaluated by a physician if you feel your child needs an antibiotic.**

Taking an antibiotic for nonspecific symptoms such as fever, cough, sore throat or cold symptoms may not only be unnecessary, but may delay the diagnosis or mask a more serious illness. For this reason, it is recommended that you do not give your child leftover medications or use an antibiotic prescribed for someone

else. **It is recommended that the full course of antibiotics be completed as prescribed, to help prevent the development of resistant infections.**

Just as with any medication, antibiotics have potential side effects. If your child is placed on an antibiotic, you should observe him/her for possible side effects.

**SIDE EFFECTS:** The most common side effect seen with antibiotic use is gastrointestinal (stomach) upset causing diarrhea and/or vomiting. **Mild diarrhea is of little concern.** Sometimes yogurt, sweet acidophilus milk or Lactinex granules (one packet four times per day) can restore the bowel's normal environment which the antibiotic disrupted causing the diarrhea. If the diarrhea is severe or is associated with rectal bleeding, you should contact your physician. If vomiting occurs with antibiotic use, make sure you are properly administering the antibiotic. Some antibiotics are required to be taken with food. If this is unsuccessful at stopping the vomiting, you should call your Physician's office. Your child may also have a side effect to an antibiotic manifested by an allergic rash. There are several different types of allergic rashes seen with antibiotic use. It is also common to have rashes caused by viruses during treatments with antibiotics. Because of these factors, it is impossible to evaluate rashes by telephone. You should do the following if your child develops a rash while taking an antibiotic:

1. Stop the antibiotic and make an appointment for your child during normal office hours.
2. Administer Benadryl (per package instructions; for dosing for children less than 6 years of age please contact your physician for dosing instructions). This may help to resolve the rash and will help with itching.
3. You should contact your physician immediately for any breathing difficulty associated with an allergic rash.

Antibiotics can cause secondary yeast infections in the mouth with little white bumps called thrush (refer to the section on Mouth Injury), and in the diaper area causing a diaper rash or diaper dermatitis. If your child develops a thrush and/or diaper rash from taking an antibiotic, contact your physician's office during regular hours.

It is possible for bacteria to develop resistance to antibiotics to which they are exposed for long periods of time. Most often, antibiotics are prescribed for only ten days, thus limiting this development of resistance. Certain types of infections such as sinus and recurrent ear infection require a longer course of treatment. Although resistance to antibiotics does sometimes develop, it is a problem which can usually be taken care of by switching to a different class of antibiotics or by giving higher doses.

Although, taking antibiotics for long periods of time is not without some risk, it is riskier to have an infection which is either untreated or under-treated. Long term consequences from prolonged antibiotic use are quite rare.

Antibiotics are wonderful drugs and have probably saved more lives than any other class of medication. **They are not a cure-all however, and are not without risk.** They should only be used at the direction and under the supervision of a physician. Old antibiotics or a partial prescription should not be taken without checking first with your physician.



## ANEMIA

Anemia is a condition in which red blood cells that carry oxygen to the body are not present in sufficient numbers. Although there are other causes, the vast majority of cases of anemia are due to iron deficiency. Symptoms of anemia include pallor (pale appearance), lethargy (drowsiness to unconsciousness), poor growth and a tendency to fatigue easily. Other symptoms of anemia exist which are less common.

If your child is diagnosed with anemia, usually an iron supplement is prescribed. The medication is usually given for several months to replenish the iron stores of the body.

Iron deficiency anemia is preventable. At birth, an infant is born with extra iron reserves. By two months of age, these stores have been utilized and the child requires extra iron. Occasionally, depending upon the nutritional status of the mother, iron supplementation is prescribed for the infant. You should consult your physician regarding recommendations for your specific child. Infants who are bottle-fed should be on formula which is fortified with iron. The use of low iron formula for infants older than two months of age is generally discouraged.

Children over the age of one should have a diet high in foods containing irons. Examples of foods high in iron are beef, pork, liver, chicken, iron fortified cereal, beans, peas, eggs, tuna, peanut butter, tomatoes, pasta, green vegetables and prune juice.

Less commonly, there are a number of genetic (family trait) causes for anemia in a child, such as sickle cell disease, thalassemia, or hemoglobin E. Some of these can represent serious health risks. Be prepared to inform your physician of any forms of anemia that has occurred in your family. All infants are screened for these disorders at birth.

## ARMS & LEGS

If the child refuses to use an arm or leg completely, you should contact your physician. If the child is limping without much pain, they should stay around the house with as little activity as possible. If the limp is not gone in 24 to 48 hours, contact your physician. A child should never be lifted by an arm or leg.

If the child suddenly begins falling a lot when he/she hasn't in the past or you notice swelling, redness or pain in the joint you should contact your physician.

## BED WETTING

Despite what you may hear from other parents, up to 50% of children will continue to wet the bed at three years of age. Many children are much older than this before they achieve nighttime bladder control. Usually children who continue to be enuretic (bed wetters) after five years of age have a parent who was late in obtaining bladder control also.

For those children who have never achieved bladder control by the age of five years, consultation with your physician is probably warranted, as there are treatment options available to them.

Children who have been dry in the past and who develop bed wetting or even daytime wetting (enuresis) need to be examined. Urinary tract infections and emotional stress are the most common causes of this.

## BITES

**Dog or Other Domestic Animal Bites:** Any animal bite that breaks the skin requires two types of management. The first is local wound care. If the wound is minor, it should be thoroughly cleansed with soap and water, and then Neosporin ointment applied. The wound should be carefully watched for signs of secondary infection (pain, swelling, redness, red streaks, fever, discharge). If these symptoms should occur or if the wound is more extensive, then contact your physician.



The second part of management of animal bites involves the prevention of rabies from the bite exposure. If the animal is well known and has been vaccinated against rabies, there is little chance that your child will catch this disease. The offending animal should be kept confined ten days and observed. If the animal is healthy at the end of ten days, the child has no need for rabies prevention. If, however, your child is bitten by a stray or wild animal, an animal which cannot be found or an animal that subsequently dies, it is very important to bring this to your physician's attention immediately.

As with any other wound, it is important that the child be up-to-date with their immunization to tetanus. After an animal bite or other dirty wound, a tetanus immunization is required if the child has not had one in the past five years. If your child is not up-to-date and they suffer a wound, you should contact your physician during regular office hours.

**Human Bites:** Human bites should be treated like domestic animal bites.

**Insect Bites and Stings:** Most insect bites and stings are not dangerous unless the child is severely allergic to a particular bite or sting.

**Treatment:**

1. If the stinger is present, remove it with a horizontal scraping motion.
2. Place a cold compress on the bite for several minutes to reduce swelling and redness of the bite or sting. Some redness and swelling are to be expected. You should contact your doctor if this becomes severe.
3. Treat with Benadryl elixir (per package instructions; for dosing for children less than 6 years of age please contact physician for dosing instructions.) and/or a paste of baking soda and water to relieve the symptoms.
4. Apply 0.5% Hydrocortisone ointment or cream to the area to help with further itching. This is available without prescription.
5. Call your physician for any difficulty in breathing.
6. Use Acetaminophen (Tempra, Tylenol) for pain. (see Dosing Guide).

**Snake Bites:** Non-poisonous snake bites are the same as bites from a dog or other domestic animal. Reptile bites do not cause rabies. If a child has been bitten by a poisonous snake, they should be taken immediately to the nearest hospital. You should make no effort to treat this yourself. Cutting the wound, oral suction, suction from snake bite kits, compresses, tourniquets, etc., are no longer recommended for poisonous snake bites.



**Tick Bites:** Most tick bites are harmless, but ticks are potential carriers for three serious diseases: Rocky Mountain Spotted Fever, Ehrlichia, Tularemia, and Lyme Disease. All three infections involve a 5 to 10 day incubation period followed by fever, muscle aches and headache. Tularemia (rabbit fever) causes swollen tender lymph nodes in areas near the tick bite. Rocky Mountain Spotted Fever and Lyme Disease can involve characteristic rashes over the entire body, but these vary greatly. If your child has a history of tick bites with any of these symptoms, it is important that they be seen by their physician.

If a tick is found, it can be removed with tweezers, grasping the tick nearest the mouth and pulling it straight out with steady pressure, followed by a soap and water scrub. It is common for a small crusty sore to remain at the site for several days. This is not an indicator of severe disease. The tick-borne diseases are much less likely to occur if a tick is removed within 24 hours of imbedding.

## **BLEEDING**

**Bleeding from the navel:** Many times in newborns, a small amount of blood is noted on the navel after the cord falls off. As long as the bleeding does not make a spot on clothing larger than a quarter, it is of no significance. The navel should be kept clean with alcohol and the bleeding will usually stop on its own. If after two or three days the bleeding continues to be a problem, contact your physician. Significant bleeding from the navel of an infant is extremely rare. If your child loses enough blood to soak a cloth diaper the size of a quarter, there is redness of the skin surrounding the navel or pus draining from the navel, contact your physician.

**Vaginal Bleeding in the Newborn:** Occasionally, because of the effect of the mother's hormones, infant girls will have a small amount of vaginal bleeding the first few days of life. This will stop spontaneously and requires no treatment.

**Nose Bleeds:** Nose bleeds can be caused by dryness of the lining of the nose or by picking or rubbing the nose too vigorously. Allergies or upper respiratory infections may aggravate the problem.

Moisturization of the nasal passages with saline (salt-water) nasal spray on a regular basis can help. Additionally, a child with recurrent nose bleeds can benefit from antibiotic ointment (Polysporin or Vasolene) applied to the inside of the nose with a Q-tip daily for several days.

To stop active nose bleeds, have the child sit up, and pinch the nose together or use an ice pack. After the bleeding stops, do not remove the clot from the nostril, as this may cause the bleeding to start up again. If the bleeding continues for more than ten minutes despite the above measures or if your child suffers chronic nose bleeds, contact your physician.

**Rectal Bleeding:** Rectal bleeding can be a more serious type of bleeding. Although it can be due to something as simple as a small tear around the rectum, children with any type of rectal bleeding should be checked by your doctor.

Other types of bleeding such as blood in the urine, coughing up blood, wounds that fail to stop bleeding, etc., of course are potentially serious and your doctor should be notified.

**Bleeding from a superficial wound:** Bleeding from an accidental cut or scrape can usually be managed by holding steady pressure over the site with a clean dry cloth. In the case of a deeper cut, the wound should receive immediate medical attention and pressure should be held on the area during transport.

## **BRUISES**

Bruises are usually normal in active, playful children. Bruises, which are particularly common, include bruises along the shin and elbows in young children. Any unusual amount of bruises or bruising noted in uncommon areas should be evaluated by your doctor.

## **BURNS**

Burns severe enough to cause blisters, breaks in the skin and all electrical burns should be evaluated right away by a physician. Burns to the hands, face and genitals are more serious than burns in other locations. Burns that merely cause redness of the skin and do not cause blisters or breaks in the skin are generally minor and require only watchful care. The following steps can be taken at home immediately after a burn to both minimize further burning and to begin treatment.

1. Hold the burned area under cool water for several minutes.
2. Use Acetaminophen (Tempra, Tylenol) for pain (see Dosing Guide).
3. An antibiotic ointment such as Polysporin can be applied and the area covered with a dressing. Clean white socks are good for protecting burns on the hands or feet. If your child has an extensive burn, clean sheets can be used for protection while on the way to the doctor or hospital.
4. If the burn results in blistering or breaks in the skin, a tetanus booster will be needed if one has not been given during the last five years.

## **CHICKENPOX (VARICELLA)**

Chickenpox is a common viral infection of childhood. After an incubation period of 10 to 21 days, a child will break out with a rash which begins as small red bumps and which very quickly form clear blisters. The clear blisters then rupture and form dark crusts. These three lesions occur in sequence. Lesions generally begin on the chest or back and then spread to the face, neck, arms, and legs. Children usually run fever for several days. In addition to this, they may have a runny nose, sore throat and/or cough. Chickenpox is highly contagious. The child is contagious one day to two days prior to breaking out with the rash and

remains contagious until all lesions have completely crusted over and there are no blisters or fever. This generally takes five to seven days from the onset of the rash. You can usually expect the child will break out with new lesions for two or three days after the first lesion is seen.

Chickenpox is generally a mild illness with no complications. If complications do occur, the most common one is secondary bacterial infection of the lesions manifested by redness and/or discharge of pus. You treat these as you would treat impetigo (see section on impetigo). Serious chickenpox complications are very rare. These involve pneumonia and encephalitis. Signs of encephalitis include headache, stiff neck, vomiting and lethargy (drowsiness to unconsciousness). If your child should become lethargic and begin vomiting, contact your doctor right away.

Shingles is a reactivation of chickenpox infection and is usually seen in adults. People with active shingles are contagious and can spread the chickenpox virus to others who have not had chickenpox. You can catch chickenpox from someone with shingles, but you cannot catch shingles from someone else. Shingles only occurs in someone who has had chickenpox at an earlier time in their life. Parents and grandparents do not need to worry about catching shingles from their children with chickenpox. Shingles is treated the same as chickenpox unless the child develops painful shingles which should prompt a physician contact. Shingles is spread by direct contact with the lesions. Keeping them covered with clothing or a gauze pad will help to prevent spread of the disease.

### **Treatment for Chickenpox:**

1. Keep your child away from other children or adults who haven't had chickenpox and from pregnant patients or patients receiving chemotherapy. Although chickenpox is usually a mild illness in children, it can be quite severe in adults. If you are unsure as to whether you have had chickenpox and your child catches the disease or has been exposed to someone with the disease, you need to let your physician know.
2. Use an antihistamine such as Benadryl for itching and trim the child's fingernails. If itching is quite severe, even with Benadryl, try Aveeno baths and an emollient lotion (**Do not use Benadryl Cream**).
3. For fever and the discomfort of chickenpox you may use acetaminophen (Tempra, Tylenol; see Dosing Guide) if your child is uncomfortable. Aspirin should be avoided because of the potential for Reye's syndrome. Fever is actually beneficial in chickenpox and should not be treated if your child is comfortable.
4. The child is contagious for about a week after the onset of the rash or until all sores have crusted over and have begun to dry.

5. It is **not** recommended that you expose your child to chickenpox in order to get the disease.
6. It is **not** recommended that aspirin be routinely used for chicken pox or fever in children.

### **Prevention of Chickenpox:**

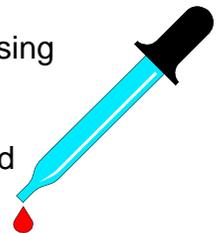
Varivax (live attenuated chickenpox vaccine) is now available and recommended for all children 12 months or older who have not yet had chickenpox. More details about this immunization are presented in the **immunization** section of this handbook. Your child's physician can also discuss Varivax with you.

## **COLDS**

At some time or another, every baby and child is going to catch cold. Colds are caused by viruses and are usually spread person-to-person from the infected nose or throat. Colds usually begin with a watery discharge from the nose accompanied by sneezing and watery eyes. The child can also develop fever, cough and a sore throat. Usually, the cough and sore throat are not particularly severe. The child may run fever for two or three days. As a cold progresses the nasal drainage often becomes thicker and may turn yellow or green. This may be the final stage in the resolution of a cold and no additional treatment is needed for several days if your child is otherwise doing well. So far, there is no cure for the common cold. Since the infection is due to a virus, antibiotics are not helpful. Treatment of colds is aimed at relieving symptoms and keeping the body well hydrated and nourished so that it can fight off the infection.

### **Treatment:**

1. Get plenty of rest.
2. Encourage plenty of fluids, especially clear liquids. This will keep the mucus thin and prevent dehydration.
3. Encourage your child to eat nutritious foods.
4. Use Acetaminophen (Tempra, Tylenol) for fever and/or aches (see Dosing Guide).
5. Saline nose drops (AYR, Salinex, Ocean) are quite helpful when placed in the nose to loosen the mucus. You should put two or three drops in each nostril, wait a minute or so and then suction the nose with a nasal aspirator (bulb syringe) as often as needed. Saline nose drops are

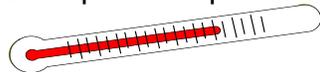
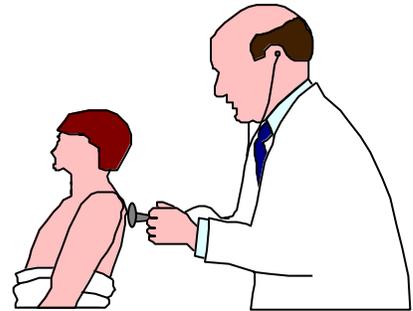


particularly helpful for very small children who are unable to blow their noses.

6. Sometimes for older infants and children, nasal decongestants and cough/cold preparations can be helpful. If your child is less than 6 months of age, consult your doctor before using these.

### You Should Make an Appointment With Your Doctor:

- A. If the nasal drainage persists after the usual 7-10 days of a cold and seems to become thicker and greenish in color.
- B. If the cough becomes particularly severe and is associated with a high fever above 102 degrees F.
- C. If your child seems to “keep a cold” year around, your child may be allergic and should be checked. Please see the Allergies section of this handbook.
- D. If your child’s temperature persists over 101 degrees F for more than three days.
- E. If your child’s sore throat is particularly severe.
- F. If your child develops ear pain.



**Do not start any left-over antibiotic prescriptions, as these drugs do not cure the common cold and can cause more harm than good. (see Antibiotic section)**

## COLIC

The term of colic has been used in various ways by people over the years. A common definition of colic is a condition in which babies, usually less than four months of age, have periods of unexplained extreme fussiness, but are normal in every other way. Typically, a regular pattern of crying develops in babies with colic. The attacks of fussiness usually occur between the hours of 3:00 p.m. and midnight, when both the infant and parents are most likely to be fatigued. The attacks are characterized by a sudden outburst of loud and more or less continuous crying. The baby is usually sucking on its fist, wanting to eat every 15 to 30 minutes, passing gas, drawing its legs up to the abdomen, flailing the arms and legs about and turning red in the face. The infant, however, is fine between these episodes of crying.

Parents are usually convinced that the baby has a stomachache or even worse that something is dreadfully wrong with the infant.

The cause for colic is not well understood. Many people assume that the baby is experiencing cramping or abdominal pain because the infant is pulling its knees up to its chest. However, babies will demonstrate this same pattern of movement with crying to anything in their environment that upsets them, such as being stuck with a safety pin or being startled by a loud noise. For these reasons, colic is probably a much more complex issue than some abdominal pain. Probably, colic is a response of the infant to many factors, including adjustments to feeding, the external environment, fatigue, perceived stress of the parents, among others. With a problem as poorly understood as colic, you can imagine the treatment is quite varied. In the past, sedatives have been used a lot, such as tincture of opium, (paregoric) and even ethyl alcohol. Most doctors do not recommend these because they can be dangerous to the infant.

Colic is a condition that the infant will outgrow, usually by the age of four months. Infants with colic will develop normally and will have no long-lasting psychological or personality defects. The following approaches may be helpful in treating your child's colic.

Check your baby to make sure there is no obvious reason for crying. Your baby should be well fed, adequately burped and appropriately dressed, including a clean, dry diaper. Your infant should have a normal temperature with nothing obviously hurting him/her. If your child has any other symptoms, consult the appropriate section of this booklet.

If the baby is breast fed, you should consider any recent changes in your diet, which might be affecting your baby. For both breast fed and bottle fed infants, attempts at frequent burping may have dramatic effects in decreasing the symptoms of colic.

Simethicone drops (Mylicon and Phazyme) are sometimes helpful in decreasing the amount of gas in the stomach. The dose is one dropperful (0.6 ml) every six hours. Again, the best way to prevent intestinal gas is frequent burping.

It sometimes helps to swaddle your baby snugly in a blanket and the rhythmic motion of a rocking chair can have a calming effect. If late at night, and holding and rocking do not help, allowing the infant to be alone in his/her crib with the room darkened for several minutes will often encourage badly needed sleep.

If the above measures are not helpful and your infant continues to cry excessively, it is possible that he/she has another problem besides colic. Consult your doctor. Unusual screaming which can not be explained or comforted and persists for more than two hours should prompt a visit to your physician.

## CONSTIPATION

**Constipation in Infants:** Parents of newborn and small infants are usually quite concerned about the character and frequency of their child's stools. Elimination is an important body function but is seldom a cause for great concern. Frequency and character of bowel movements in infancy are quite variable. Some infants may have a stool with almost every feeding, while others only have a stool every three to four days. Both of these patterns are normal. Most breast fed babies tend to have frequent, watery stools. Formula fed infants may have thicker and less frequent stools. This is especially true for the first three weeks of life, but may not be the case thereafter.

Parents are often concerned about constipation in their infant because of straining during a bowel movement. Part of a newborn infant's normal behavior is grunting and straining to pass stools. The infant will often turn red in the face and seem to be having difficulty in passing his/her stools. This behavior is normal. As long as your baby is having a stool every three to four days and is not having an extreme amount of difficulty in passing the stool, his/her bowel habits are normal. If, however, the stool is extremely hard or the child has to strain excessively to push out firm balls, he/she is probably constipated.

**Constipation Treatment in Infants:** Since constipation by definition is having hard stools which are difficult to pass, the treatment is aimed at softening the stools. If your baby's stools are soft, he/she needs no treatment for constipation. The following measures are usually helpful for constipation.

1. If your infant is crying in pain from a hard stool which is difficult for him/her to pass, one-half of a glycerin suppository can be inserted. These can be obtained without a prescription, but should not be used often.
2. To loosen the stool in older infants, give prune juice which is diluted half with water three times per day. Other juices like apple juice can also be effective.
3. If juice is not effective, or in younger infants, try Milk of Magnesia, starting at a dose of one-half teaspoon daily. These can be mixed with the baby's formula and given in a bottle.
4. Honey is no longer recommended in the treatment of constipation because of the potential for infant botulism poisoning.

**Constipation in Older Children: Occasional** constipation in older children can be safely treated with a lubricant laxative like Milk of Magnesia, with a daily dose of one to three teaspoons until soft, non-painful bowel movements are achieved. More chronic constipation may require a significant long term increase in dietary fiber and/or a bulk laxative such as Metamucil (one heaping tsp. in at least an 8oz beverage daily). Unprocessed bran is an inexpensive, effective source of

fiber and can be added to many foods including cereal (one to two tsp.), hamburger, pancake batter, or any baked goods.

Less often, children can develop severe chronic constipation, sometimes with leaking of stool (encopresis). This problem requires a more detailed evaluation and therapeutic plan, and your child's physician should be consulted.

## **CONTAGIOUS DISEASE**

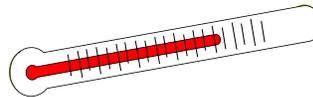
Your child will be exposed to a great number of minor, self limited contagious diseases on a daily basis through family, day care, school, and other social contacts. These risks can be minimized by simple hygienic measures such as frequent handwashing. Most illnesses do not represent a danger. Rarely, however, exposure can occur to serious infectious illnesses such as measles, hepatitis, or spinal meningitis. There are very specific recommendations for each of these, and your doctor's office should be contacted.

## **COUGH**

The cough reflex is the body's defense mechanism against mucus accumulation in the bronchial tubes. Cough is very common and is usually not serious. Coughs frequently accompany an ordinary cold.

Coughs which need to be evaluated further are those which:

1. Are accompanied by high fever.
2. Persist for more than seven days.
3. Interfere significantly with sleep and daily activities.
4. Are accompanied by difficulty in breathing.



Any of the before mentioned symptoms should prompt an appointment during regular office hours except coughs accompanied by difficulty in breathing which require immediate care.

## **CROUP**

Croup is a viral infection of the upper part of the airway and voice box. It is most common in younger children and is associated with low-grade fever, hoarseness and a loud barking cough. Although croup is usually not serious, occasionally a child with croup can have an attack with breathing difficulty especially at night. During these attacks, the child will have difficulty drawing his/her breath in.

## Treatment of Croup:

Give the child plenty of clear liquids and use a vaporizer to keep the secretions moist (a cool mist is recommended).

Treat the fever with acetaminophen (Tempra, Tylenol, see Dosing Guide).

During an attack of breathing difficulty, place the child in the bathroom, turn the shower on hot and fill the room with steam. Fifteen to 20 minutes in this environment will often relieve the attack. If these measures fail to help and he/she continues to have difficulty breathing, you should see your physician.

If your child develops an inability to swallow manifested by constant drooling and has the above symptoms of barking cough, fever (usually high), hoarse voice and difficulty breathing, he/she may have a serious bacterial infection of the throat called epiglottitis. **Seek help immediately if this occurs.**

## CRYING

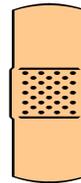
Continual crying in an infant, of course, is not normal. After the age of four months, the incidence of crying in a small child decreases dramatically. Many times, continuous crying can signify a medical problem. Please refer to the section on infant colic. If these measures are not helpful in calming your child and he/she has cried continuously for more than two hours, you should see your physician.

## CUTS & SCRATCHES

These should be treated in the following manner to prevent infection and to aid in healing with less scarring.

1. If there is any possibility that stitches might be required, the child should be brought in for an evaluation. Stitches cannot be placed after 6 hours from the time of injury.

2. Clean the area thoroughly with soap and water. Cover with an antibiotic ointment such as Polysporin. A clean bandage should be applied.



3. A clean, minor wound should require no tetanus booster if your child is up to date on his/her immunizations. If the wound is dirty or deep, and it has been more than 5 years since the child's last tetanus shot, then a booster is indicated within 24 hours of the injury. See immunization section for more details.

4. ***Alcohol, Campho-Phenique, first aid cream, iodine, Mercurochrome and Merthiolate are not recommended, as they can injure the tissues.***

## DAY CARE

Carefully choose a day care for your child that has the same concerns for his/her health that you do. Choose a day care with an appropriate worker to child ratio. Ideally this is one worker per six children or less. Try to limit your child's exposure to children with fever and other infections. In turn, it is recommended that you not take your child to day care or to the baby-sitter when he/she is sick.

## DIARRHEA & DEHYDRATION

**Diarrhea** is characterized by frequent, loose, watery stools. It is most commonly caused by a viral infection in children, and is called gastroenteritis. This causes the stomach and intestine cells to become sick and to slow down and even stop their normal function (absorbing fluids and nutrients). Gastroenteritis often begins with vomiting and fever. Then, after several hours, the vomiting resolves and diarrhea follows. There are other more rare causes of diarrhea, including diarrhea due to bacteria (*Salmonella* and *Shigella*), parasitic infections and milk allergy. The vast majority of the cases of diarrhea are due to common viral infections.

### Treatment of Diarrhea:

The treatment approach to diarrhea is the same as the treatment outlined in the vomiting section. The main concern with diarrhea is that dehydration (lack of fluids) may result. The goal with treatment of diarrhea is to prevent this until the intestine can recover and begin its normal function.

*The routine use of medications to stop diarrhea is not recommended unless specifically prescribed by your physician.* Certain types of diarrhea can be dangerous to stop with an Anti-Diarrheal medication. These particular medications work by paralyzing the intestine and not by reversing the diarrhea process. The underlying cause of the diarrhea must be treated, not masked, and this is done by diet.

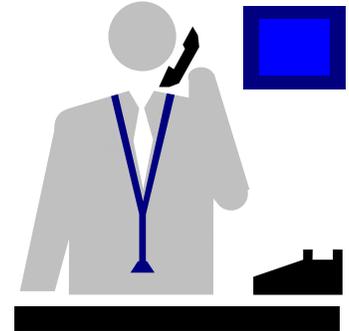
**Dehydration** results when there are excessive fluid losses from the infant or child, usually a result of vomiting or diarrhea. Dehydration is serious and should be evaluated by a physician. Signs of dehydration include:

1. Dry mouth. Place your finger inside the child's cheek and then rub your thumb and forefinger together. If it is wet, there is no need to worry about dehydration. If, however, it feels sticky, tacky or definitely dry, then dehydration may be present. A child that is drooling is not dehydrated.
2. Poor urine output. Infants and children usually urinate at least once every eight hours. Decreased urine output in the presence of diarrhea may mean that dehydration is present.

3. Tears. If your child is making tears when he/she cries, then there is little chance of dehydration. If there are no tears when your child cries, this could possibly indicate dehydration when taken with other symptoms outlined above.
4. Lethargy (drowsiness/unconsciousness). If your child or infant is not alert or shows little interest in his/her surroundings and normal activities such as eating and playing, this may be a sign of dehydration when taken into consideration with the above signs of dehydration.

### You Should Make an Appointment with Your Physician If:

1. Signs of dehydration are present.
2. The diarrhea is associated with high fever over 103 to 104 degrees F. and is unresponsive to acetaminophen (Tylenol, Tempra).
3. If pus or blood is noted in the stool.
4. If diarrhea persists for more than three days despite diet changes listed under the section on vomiting.



## EAR PROBLEMS

**Ear Ache:** Many times in children, an ear ache is due to an ear infection, although there are other possibilities. Most ear aches, especially when they are associated with fever, should be evaluated by your physician. *Medications are not generally prescribed for an ear ache by telephone since it is difficult to determine the problem and prescribing antibiotics without a proper diagnosis is dangerous to your child (see section on antibiotics).* Other problems, which can cause an ear ache, relate to an inability to equalize pressure in the ear following a cough, sneeze, or crying episode, etc. Many times, this can be relieved with a few minutes of rest. An antihistamine/decongestant preparation can help with this if the tubes in the ear are blocked.



To provide relief for your child at home prior to calling your physician, the following measures can be tried:

1. Use Acetaminophen for pain (Tempra, Tylenol - see Dosing Guide).
2. Rest your child's head on a hot water bottle or heating pad. This may help relieve the pain.
3. If there is no drainage from the ear and if you have some Auralgan drops on hand, they may be placed in the ear to relieve the pain. Do not use Auralgan drops if there is drainage or if your child has pressure-equalizing tubes. Remember that an ear ache is usually worse at night and you should contact

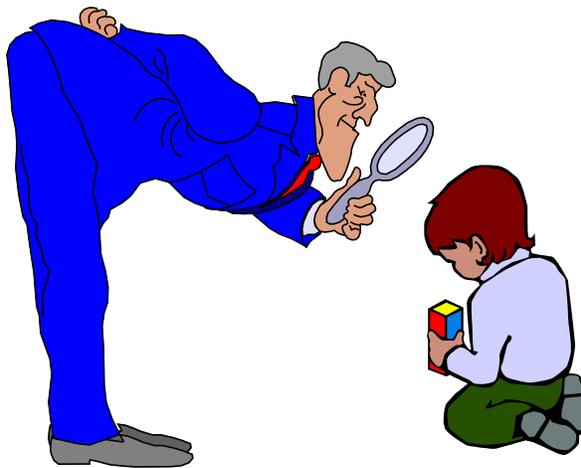
your physician the following day even if he/she seems better.

4. If you have a cough/cold preparation containing codeine such as Phenergan with codeine, Tylenol with codeine or other codeine containing medicines, these can be given every few hours as needed (see Dosing Guide). If the ear ache is severe enough to require codeine to get the child through the night, then you should bring him/her into the physician the next day even if he/she seems fine. This medication, of course, does nothing for the infection, it only relieves the pain.
5. Children who develop ear ache and fever should be seen by your doctor within 24 hours of the onset of their illness.
6. Old prescriptions should not be given to a child with a new onset of an ear ache.

**Draining Ear:** If your child's ear is draining pus, then the child should come in for an examination. It is possible that he/she may have a torn ear drum. *This is not usually a serious condition and the ear drum will heal.* The child should come in for an office visit during office hours. A cotton wick made from a cotton ball may be placed into the ear to absorb the drainage.

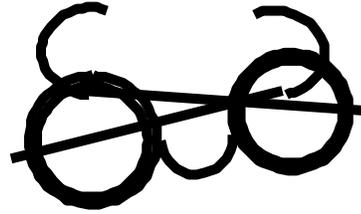
**Hearing Problems:** All hearing problems should be evaluated during regular office hours.

**Object in the Ear:** Rocks, seeds, beans and other small objects that are placed in the ear by a child should be removed during your physician's regular office hours unless the child has pain or bleeding.



## EYE PROBLEMS

**Newborn:** There are three minor problems with the eyes of newborn babies that parents should be aware of. The first is mildly swollen or irritated eyes appearing in the first few days of life which may be a reaction to antibiotic drops which are placed in the baby's eyes at birth. The incidence of this problem has decreased due to a change in the medicine now used. Usually, the swelling and irritation will resolve without treatment in a few days. If the swelling increases, if the eyes drain a yellow or green discharge, or if the eyes themselves are red, then the child should be checked.



Infants may also have a blocked tear duct. Blocked tear ducts in an infant or child causes the eyes to water excessively. The treatment for this is massaging the tear duct with the index finger at the inner corner of the eye. Pressure should be applied in a downward direction. This will help open the tear duct. You should discuss this problem with your physician during a routine office visit.

Many young infants can have intermittent crossing of the eyes. This usually resolves spontaneously by six months of age. If it continues past this time, discuss this with your physician.

**Pink Eye:** Pink eye or conjunctivitis is a mild inflammation of the outer lining of the eye manifested by redness and discharge from the eye. It is most often due to a mild infection although there are other causes including irritation from dust and allergy. Sometimes, conjunctivitis can be associated with infections in other parts of the body, especially ear or sinus infections. Some forms of pink eye are contagious and can be passed on by touch contact the way common colds are spread. Because pink eye has so many causes and is many times associated with other infections, it is difficult to evaluate this by telephone. If your child develops pinkeye, you should contact your physician to schedule an appointment.

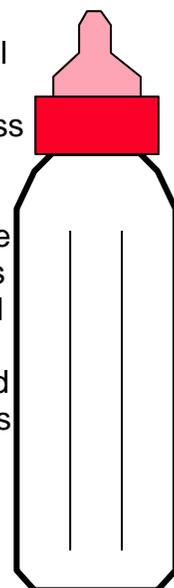
**Eye Trauma:** Trauma to the eye that results in significant pain that does not go away in a few minutes should be evaluated on an emergency basis.

**Eye Pain:** Any severe eye pain, even if it is not associated with trauma, should be evaluated on an emergency basis.

## FEEDING

**Newborn:** For most newborn infants, breastfeeding is the preferred choice. Breast milk has many advantages including optimal nutrition, establishment of strong emotional ties between the mother and infant, providing anti-infectious factors to the baby from the mother, cost savings, ease and convenience of food preparation, among others. Sometimes, however, breast feeding is not an option and there are many excellent infant formulas available. Please contact your physician for advice. All should be on Vitamin D Supplement.

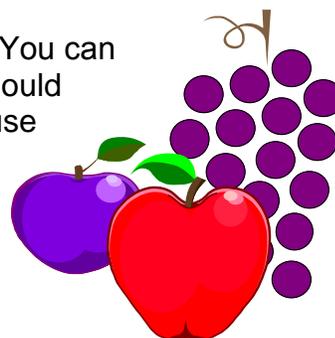
**Four to Six Months:** During the first four months of life, breast feeding and infant formula provide all of the calories, water and nutrients that your baby will need. It is generally recommended that solid foods be started at four to six months or when your child is physically ready to swallow them. Solids have less calories per unit volume than both breast milk and formula. Because of these two considerations, it is recommended to wait until four to six months of age to start them. Rarely, some babies may need to begin solids earlier than this time as directed by your doctor. The goal of introducing solid foods into your baby's diet is to provide a starting place for a more mature diet. Your baby's first solid food should be iron fortified infant cereal. There are three cereals available: rice, barley and oatmeal. Any of these are fine to use. The first feeding should usually be one tablespoon mixed with either breast milk, formula or water. This should be increased gradually.



Vegetables can also be started at four to six months of age. These should be single component foods, such as carrots, squash, and green beans.

After a new food is introduced into your child's diet, you should wait three to four days before introducing another food because of the possibility of food allergy. Vomiting, diarrhea, rash, colic, runny nose, irritability and sleeplessness can be signs of a food allergy. If these should occur after the introduction of a new food, you should discontinue it and report this to your physician at your next regular visit. Each feeding that your child receives should be followed by milk or water. The amount your child eats should depend upon his/her desire. Give as much as your child wants, but do not insist the child eat when he/she is no longer interested.

The next food to introduce in your child's diet is fruit. You can introduce a new fruit every three to four days. You should initially use individual fruits and not mixed fruits because of the need to identify which food your child might react to. It is generally recommended starting with vegetables first, then fruits. Fruits are much sweeter and your child will prefer these over vegetables if you start them first.



Meats are the last foods that you should introduce into your baby's diet. They have the highest protein content and are most difficult for the infant to digest. It

is usually recommended that meats be delayed until the child is approximately seven to nine months old. After your child has tried all the individual foods, mixtures may be introduced for variety and convenience.

Juices such as apple, pear, etc., can be added to the diet at the same time the fruits are added. These are not essential to the diet, but are a good source of extra fluid and calories, and may be given at any time during the day.



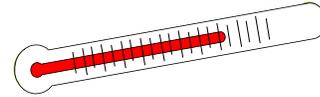
**One Year:** The first year of life is your child's period of most rapid growth. After about 12 months, the rate of growth slows down and parents notice that the child's appetite decreases. Many times, parents become very concerned that their one-year-old child seems to be eating less. Part of your regular doctor visits should be to plot height, weight and head circumference of your child. As long as his/her

growth percentiles are within the normal range and the blood count is normal, you can be assured that your child is receiving adequate nutrition.

After the age of 12 months, usually breast feeding and/or formula is discontinued and cow's milk is introduced into the diet. Whole milk until two years of age and then 2% milk thereafter. Consult your physician for their advice. Once off the bottle, your child's calcium and protein needs can be met by a minimum of 6 to 8 ounces of milk per day. If he/she hates milk, yogurt and cheese make satisfactory substitutes. It is a good idea for young children to have mealtimes at a regular hour each day. Between meal feedings are usually not a good idea, although there are exceptions. A balanced diet from all food groups is recommended, however, you should not force a child to eat food he/she does not want. Simply make foods available to your child. At 12 months of age, the use of bottles should be exchanged to the use of a cup.

Frequently parents have questions about the use of vitamin supplements for their child. There is no question that breast feeding provides the best nutrition for your baby. However, adding fluoride to the diet is sometimes a good idea for breast fed infants. This supplementation is generally begun at the 4 month visit. The purpose of adding fluoride is to prevent tooth decay. Adding fluoride is not necessary in bottle fed infants if the formula is mixed with water containing adequate amounts of fluoride. Most communities have water supplies with adequate levels of fluoride. If you have questions concerning this, contact your local water authority and discuss any questions at your next well-child exam.

## FEVER



**Stay calm, don't panic!** Fever is a sign of illness and not an illness in itself. Fever alone is not dangerous. Contrary to wide belief, fever does not cause brain damage, even high fevers of 105 to 106 degrees F.

Fever should be viewed as the body's normal response to fighting infection. Fever is caused by "pyrogens" which are substances released into the blood stream by the body's white blood cells as they attack invading bacteria or viruses. Thus fever is a normal response of the body to infection. It is interesting that bacteria and viruses are killed more efficiently at higher temperatures. Chickenpox for instance is less severe if the fever is not treated (fewer lesions, less scarring, shorter duration of illness). In addition, with fever the degree of temperature elevation is frequently not related to the severity of the infection. Minor viral infections typically have quite high fevers and, of course, are not serious. *Because of these considerations, fever alone should not cause alarm and is almost never an emergency.* A much more important aspect of the management of fever is determining if your child has a serious infection as the cause of the fever.

If you feel your child has a fever, take the temperature. For children under three years of age, the rectal temperature is the most accurate and simplest to take. This is done by lubricating the thermometer with petroleum jelly (Vaseline) and inserting it into the child's rectum approximately one inch. Remove the thermometer after two minutes. Fever is defined as a temperature above 100.5 degrees F taken rectally. The temperature may also be taken under the arm (Axillary) or under the tongue (Oral). The rectal temperature is usually one degree higher than an oral and two degrees higher than an axillary temperature. You should note the actual temperature and report the method used. If you use a tympanic (ear) thermometer and you suspect your child's temperature is higher than the reading, re-take your child's temperature either orally or rectally. It is not recommended to use the ear thermometer in children under 6 months of age due to their small ear canals.

### Treatment of Fever:

1. Acetaminophen (Tempra, Tylenol), or Ibuprofen (Advil, Motrin, See Dosing Guide). **It is not recommended that aspirin be routinely used for fever in children. Ibuprofen should not be given to children under the age of 6 months.**
  2. Dress your child in loose fitting clothing such as a T-shirt and underwear or a diaper. Do not bundle your child tightly or cover him/her with a blanket because this will only make the temperature rise further.
  3. Give your child cool liquids to drink.
- If your child has a high fever which does not respond to the above measures within 30 to 60 minutes, you should lower his/her temperature by giving him/her a

sponge bath with lukewarm water. To do this, place your child in a tub of lukewarm water and sponge him/her off thoroughly. Use a cup and pour water over his head. This will even be more effective in bringing the temperature down. You can expect your child to shiver very vigorously during the sponge bath. This is no cause for alarm.

**Your Child Should See the Doctor When:**

1. Your child has a prolonged fever above 101 degrees F for more than 48 hours. Contact your physician during regular office hours for an appointment.
2. Your child has fever plus any sign of minor infection such as sore throat, ear ache, pain on urination, cough or mild rash. Contact your physician during regular office hours for an appointment.
3. More significant problems such as breathing problems, severe headaches, stiff neck, inconsolable irritability, lethargy, seizures, a bruise-like rash, etc., of course, demand prompt attention from your doctor when they occur.
4. Fever above 100.5 degrees F taken rectally in infants younger than three months is significant even in the absence of other symptoms. *This is the only instance of a true emergency with fever as the only sign of illness.* The physician should be notified with any infant with fever.

The physician should be notified with any high fever above 104 degrees F which is unresponsive to acetaminophen and sponge baths. If you child's fever comes down with the above measures, then there is not cause for alarm from the fever.

## GENITALIA

**Boys:** Circumcised boys will often get irritation and redness at the opening of the urethra (the small hole at the end of the penis) called meatitis. Chronic meatitis can cause the opening of the penis to be scarred and too small. This is treated with an antibiotic ointment applied several times per day. Another problem with circumcised boys is adhesion of the skin to the head of the penis at the area of circumcision. This can be checked during a routine examination.

Uncircumcised boys can have problems with inflammation of the foreskin. If this occurs, contact your physician.

At the time of birth, the foreskin is attached to the underlying head of the penis. If your child remains uncircumcised, it should not be forcibly retracted. By the time your boy is three years old, the foreskin can usually be retracted. When the foreskin can be easily retracted, you should do this during each bath for hygiene purposes.

Testicular pain and swelling at anytime during a boy's life is not normal. Contact your physician promptly if this occurs.

**Girls:** Vulvovaginitis. This is an irritation of the external genitalia usually occurring in young girls. It is sometimes caused by decreased attention to good hygiene. Bathing in bubble bath or soapy water can make this worse. Other causes of this are infections with yeast and certain types of bacteria. Treatment for this problem includes:

1. Improved hygiene - teach your child to wipe from front to back and have her put on a clean pair of cotton underwear daily. In addition, a Sitz bath (shallow sit down bath) in warm tapwater for 10 to 15 minutes twice daily for four to five days is often helpful.
2. If this is not helping the child, she should see her physician. A small amount of bleeding in this area with vulvovaginitis should not alarm you, but should prompt a call.

Any bulges in the groin area in both boys and girls should raise your concern about a possible hernia. A hernia is caused by a defect or small opening in the muscular abdominal wall which allows for a portion of the intestine to protrude through it, producing a bulge which is usually found in the groin area. Typically, the intestine will move easily back and forth through this opening and the bulge produced by the hernia will often appear when the intra-abdominal pressure is increased such as with crying. The bulge will often disappear when the abdomen is relaxed.

The danger of a hernia is that the intestine can protrude through the opening in the abdominal wall and somehow become twisted or swollen so that it is unable to return to its proper position within the abdominal cavity. When this happens, the hernia is said to be incarcerated and the bulge of a hernia becomes firm, and often red and painful. This results in intestinal obstruction and vomiting. An incarcerated hernia is a surgical emergency and the physician should be notified immediately.

## **HEAD INJURY**

*Most head injuries in children are relatively minor and are seldom severe enough to justify the hours that parents spend worrying about them.* There are a variety of signs and symptoms to watch for following a head injury during the first 24 to 48 hours. You should observe your child for the following symptoms and report them to your doctor as instructed.

1. If your child loses consciousness, you should immediately contact the physician.
2. Drowsiness. Most children will become drowsy after a head injury and sleep. It does no harm for your child to fall asleep. In fact, this is very common. It is important, however, to make sure that your child can be fully aroused. It is a

good idea to awaken your child every three to four hours during the night after a bad blow to the head. If you have difficulty in waking your child, you should report this to your doctor.

3. Any convulsion or seizure following head trauma should be reported to the doctor.
4. Double vision or other visual problems should be reported to the physician.
5. Unequal pupils should be reported to the doctor.
6. Weakness in one arm or one leg should be reported to the doctor. Any limp or staggering which persists more than a few minutes after the head injury should be reported.
7. Any abnormal leakage of fluid from the nose or ears should be reported.
8. Vomiting. Vomiting is common following even minor head trauma. If it persists more than twice following the trauma, you should report this to the doctor.
9. If your child develops slurred speech or is unable to speak, you should contact the doctor.
10. Headache. This is a common symptom after head injury. If it persists or becomes increasingly severe, you should notify your doctor.

If your child exhibits none of the above, then it is very unlikely that your child has sustained a significant head injury. A hematoma (a collection of blood under the skin at the site of the head trauma) or “goose egg,” as some parents call them, is not serious unless they are huge (size of a baseball). This problem will resolve on its own.

## **HEADACHE**

Headache is not as common in children as in adults. Any recurring headache or headache associated with vomiting, poor coordination or other symptoms should be evaluated by your physician. Mild infrequent headaches can be treated with acetaminophen or ibuprofen. Headaches associated with fever and a stiff neck are potentially serious and should be evaluated by your physician right away.

## IMMUNIZATIONS

Immunizations are a very important tool in preventing serious childhood diseases. In many states, immunizations are required prior to school admission. It is imperative that you keep an immunization record for each of your children. This record should be completely up-to-date and always available. It is a good idea for parents to keep this information with them. It is your responsibility to always keep up with your child's immunization records because this may be very important at the time of accident or illness. See page 2 for the recommended schedule of immunizations.



**DTP/DTaP Vaccine:** **DTP** (Diphtheria, Tetanus, and Pertussis) vaccine has been administered to healthy children in the U.S. for more than 40 years. It is a killed cell vaccine (components from the bacteria are used to make the product). The vaccine is given at 2, 4, 6, 15 to 18 months, and at 4 to 5 years of age. Potential minor side effects occur in about 1/3 of children, and consist of low grade (less than 102 degree) fever, local soreness or swelling at the injection site, or irritability. These are self limited, beginning within hours of the immunization and lasting less than a day. A small knot at the site may persist for several weeks before resolving. Tylenol or other brand of acetaminophen (see dosing guide) may be used to minimize these symptoms. Rarely, (about one chance in 3,000), a more severe reaction may occur, such as a high (more than 105 degree) fever, convulsion, or an extreme weak, pale appearance. These problems are also temporary, but are frightening and your child's physician should be notified immediately if these occur. DTP has also been associated with a very rare risk of long term injury. However, when compared to the hazard of death or damage from the disease Pertussis, normal healthy children are felt to be far safer with the vaccine despite the above risks. A new approved vaccine is the **DTaP** - (Diphtheria, tetanus, and acellular pertussis) vaccines are efficacious when administered to infants as the primary series (i.e., doses 1-3). In addition, local reactions, fever, and other systemic events occur substantially less often after diphtheria, tetanus, and acellular pertussis (DTaP) administration than after administration of whole-cell diphtheria, tetanus, and pertussis (DTP). Therefore, diphtheria, tetanus, and acellular pertussis (DTaP) vaccines are recommended for all five doses in the vaccination schedule. For children who have started the vaccination series with one, two, three, or four doses of whole-cell diphtheria, tetanus, and pertussis (DTP); diphtheria, tetanus, and acellular pertussis (DTaP) is also recommended for all remaining doses in the schedule. During the period of transition from use of whole-cell diphtheria, tetanus, and pertussis (DTP) to diphtheria, tetanus, and acellular pertussis (DTaP), whole-cell diphtheria, tetanus, and pertussis (DTP) is an acceptable alternative to diphtheria, tetanus, and acellular pertussis (DTaP) for any of the five doses.

**Polio Vaccine:** Polio vaccines have been routinely administered to U.S. children since the 1950's, and they have produced the elimination of paralytic polio in our country. The vaccine in use is the Inactivated Polio Vaccine, and this is given at 2 and 4 months of age followed by booster doses at 12-18 months and 4-5 years.

**MMR** (measles, mumps, rubella): The MMR is also a live virus vaccine, and it is given by injection at 12-15 months of age, with a booster dose at age 4-6 years. Severe side effects are extremely rare, but children can occasionally develop a measles-like rash and/or low grade fever from 1-2 weeks after the immunization. This reaction is typically brief and self limited, and requires nothing more than acetaminophen for treatment. The same precautions as those for oral polio vaccine also apply to the MMR since both are live vaccines. Also, children highly allergic to egg might possibly react to MMR. Let your doctor know about possible egg allergy prior to immunization.

**HIB** (Hemophilus influenza type B vaccine): This immunization prevents serious infections due to the H flu bacterial germ, the most common cause of spinal meningitis in childhood. The Hib vaccine has been routinely given to all children for about a decade, and is now combined in the same shot with DTP vaccine. This vaccine is extremely well tolerated.

**Hepatitis B:** This vaccine is given to protect your child against the Hepatitis B virus, which can cause problems with the liver. This vaccine is given as a series of three doses, with the first right after birth, the second dose 1-2 months after and the last 6 months later. This is also a vaccine with a very safe track record.

**Chickenpox** (Varivax): Chickenpox vaccine is the newest addition to the routine childhood immunization series. This is a live virus vaccine (similar to MMR) and is recommended for every child older than age one who has not had chickenpox. It is given as a shot and consists of a single dose to younger children, or a two dose regimen if the child is 13 years or older. Side effects are few and consist of occasional soreness at the site of injection, mild flu-like symptoms, or rarely, a few chickenpox spots. The same precautions should be observed as for the polio vaccine.

**Pevnar:** Pevnar is a pneumococcal vaccine, which helps prevent childhood diseases caused by the bacterium Streptococcus Pneumoniae. These infections are the most common invasive bacterial infections in children. Pevnar is recommended for use in all children 23 months of age and younger and for children ages 24-59 months who are at high risk of invasive pneumococcal infection. Since the immunization schedule depends on when your child receives their first dose, see your physician for their recommendations.

**TB Skin Test:** This is not an immunization, but is a test that is done to determine whether your child has been infected with tuberculosis, a chronic and severe lung disease. It is sometimes a part of routine health visits at 12-15 months of age, and is definitely indicated if a family member has the disease.

**Tetanus:** Tetanus (lock jaw) is a disease which is caused by a bacteria which can grow in contaminated wounds. The bacteria can produce a toxin or poison which causes serious muscular spasms. Dirty wounds (those contaminated with dirt, feces, soil and/or saliva), or deep puncture wounds are particularly tetanus

prone. Universal immunization with tetanus vaccines has virtually wiped out tetanus in the United States. Children who suffer more serious wounds should have particular attention paid to their immunization status. If your child has had three or more DTP vaccine doses within the past 5 years, then he/she does not require tetanus immunization after a dirty wound. *If 5 or more years have elapsed since the last immunization to tetanus, then a booster will be required at the time of the injury. Children and adults should receive a tetanus immunization at least every ten years even if no wounds have occurred.*

## **IMPETIGO**

**Impetigo** (skin infection): Impetigo is a minor superficial infection of the skin. It is common during the summer months and is characterized by yellow, weeping sores which are usually located on the face, arms and legs. Impetigo is usually due to Strep or Staph infection.

### **Treatment of impetigo consists of:**

1. Washing the sores daily with soap and water, thus removing the crusty lesions.
2. Applying Neosporin topical antibacterial ointment to the sores.
3. If the areas are particularly bad, you should contact your physician. Sometimes, oral antibiotics are necessary to completely resolve the infection.
4. Other measures can be taken to make your child more comfortable. These include keeping the fingernails trimmed and giving Benadryl for itching (see Dosing Guide).
5. Sores with surrounding angry-looking red areas or red streaks should be seen by your physician.
6. If your child has more than one sore, make an appointment with your physician.

## **ITCHING**

Itching due to insect bites, rashes and chickenpox can be treated with Benadryl Elixir (per package instructions; for dosing for children less than 6 years of age please contact your physician for dosing instructions). This can be given every four hours as needed. It is also a good idea to trim fingernails to protect the skin from scarring.

## JAUNDICE

Jaundice refers to a yellow tint of the skin usually due to liver immaturity in newborns or liver disease in older children. In these conditions, bile pigments accumulate in the blood stream and are deposited in the skin. It is the liver's job

to rid the body of these bile pigments. The liver of a newborn infant is not mature enough to do this job hence the bile pigments accumulate and the child can become jaundiced. Usually by five days of life, the infant's liver is mature enough to take care of the bilirubin load. Most all babies develop some degree of jaundice which is a little more pronounced in breast fed babies. *It is rarely a cause for concern.* If jaundice develops in the lower legs and/or feet or lasts more than five days, call your physician for an appointment.

Jaundice which develops after the newborn period can be due to liver disease. All such children who develop jaundice should have a routine office visit to check this.

Sometimes, young children who eat a lot of yellow vegetables (carrots and squash) develop a yellowish tint to their skin, but not in the whites of the eyes. This is known as carotenemia and is not truly jaundice. It is harmless, requires no treatment and resolves with age.

## KIDNEY & URINARY PROBLEMS

Any symptom suspicious for urinary tract infection, including painful urination, urinary frequency or urgency should be evaluated by your physician.



Other common types of urinary problems involve irritation of the **urethra**. This occurs especially in girls who take bubble baths or add soapy substances to their bathwater. It is generally recommended that substances such as bubble baths, dish washing liquid, bath oil, bath beads or additives be avoided.

If your child develops problems with night-time or even daytime **wetting** (enuresis), please consult the section on bed wetting in this booklet.

## LEG & ARM PROBLEMS

If your child refuses to use his/her arm or leg completely, you should contact your physician. A limping child who has no fever and is not in much pain should be evaluated if the limp has failed to disappear after 24 hours. Of course, any swelling, redness or pain in the joint, associated with fever, is a cause for immediate concern and the physician should be notified.

In-toeing and out-toeing when a youngster walks is a common problem and should be discussed at a routine check-up visit.

## LICE & SCABIES

**Head lice** are a common affliction among school age children and their families. Lice are not a danger and do not convey serious disease, but they can be a frustrating problem to deal with. Here is the best current advice for getting rid of these pests.

1. Treat the hair with Nix Creme Rinse or similar product. These are available without prescription. Follow directions included carefully. This should be repeated once in 7-10 days if new nits are seen. If there are repeated failures, lindane 1% (Kwell) shampoo is available upon a doctor's prescription. Note that lice are not killed by regular shampoo and water. All family members should be checked if one is found to have head lice.
2. If removal of the nits (eggs attached to the hair shafts) is difficult, soak the hair with white vinegar and then apply a damp towel soaked in vinegar to the hair for 30 minutes. Use a fine-toothed comb to help remove nits. Some nits may actually need to be removed by pulling the nit down the hair shaft. It is very important that all nits be removed, since live eggs can hatch every 7-10 days.
3. Clothing, bedding, towels and cloth toys should be machine washed in hot water (above 125 degrees) and dried on high heat for 20 minutes. Clothing that cannot be machine washed should be dry cleaned or placed in a sealed bag for at least 10 days. Combs, brushes and hair barrettes should be carefully cleaned on the same day as treatment.
4. Vacuum the house thoroughly. Be sure to vacuum beds and furniture.
5. Discuss with your child the importance of not sharing coats, caps, hats, combs, brushes and bows with friends or classmates.
6. If you find that your child has head lice, please inform his/her teacher so that other students may be checked. This may help your child from becoming re-infected.
7. A home remedy for head lice, which has been effective, involves the use of mayonnaise. The mayonnaise suffocates the head lice. Directions for using mayonnaise:
  1. Apply 100% real mayonnaise. Do not use "light", low fat, fat-free, or Miracle Whip.
  2. Apply mayonnaise generously to the hair, working it in thoroughly to the scalp.
  3. Cover the hair with a shower cap for 3 hours.
  4. Rinse out the mayonnaise with warm water and shampoo.
  5. Pick out the dead nits from the scalp until they are gone.
  6. Repeat process weekly as needed.

8. If you have carefully followed these guidelines and the lice continue to be a problem, consult your doctor's office for further advice.

**Scabies** are human mites that burrow into the skin and create a severe itchy rash over several areas of the body; characteristically the spaces between the fingers are involved, and the infection can last for months and spread to others if untreated. A visit to the doctor is indicated when this condition is suspected, in order to be sure about the diagnosis, and to discuss treatment.

## **LUMPS, LYMPH NODES & KERNELS**

Children normally have lymph nodes which can be felt in the neck, especially under the chin, but also in other areas. As long as they are small, movable and nontender, they are of little consequence. A lump that is rapidly enlarging, is red and tender, or is associated with fever should be evaluated by your physician.

## **MOUTH PROBLEMS**

**Mouth Injury:** (see Teeth section)

**Thrush:** Thrush is a yeast infection of young children which causes fever and white patches on the inner surface of the lips, gums and throat. It lasts a few days and can be uncomfortable for your child. It is best treated as follows:

1. Encourage fluids to ensure that your child stays well hydrated. Try to avoid carbonated beverages or fruit juices which will worsen discomfort. Milk, ice cream, pop-suckles and Jello are all good choices.
2. Your doctor may need to evaluate and treat this problem.

## **PINWORMS**

Pinworms look like tiny white threads. They live in the intestines of children and adults which are infected with them. At night, they travel to the rectal opening and lay eggs on the outside of the skin. This causes tremendous itching of the child's bottom and can cause restless sleep. You can check for pinworms by examining your child's skin about the anal opening with a flashlight in the wee hours of the morning. Usually, the best time to check your child is around midnight. This infection is spread by passage of eggs from the infected person to others. Pinworms, however, represent no danger to your child.

Pinworms require treatment with medication to relieve the infestation. Your physician can check for pinworms during a routine office visit. When an infection is identified, all family members should be treated for the infection. At the time the family members are treated, underwear and bed linens should be changed and washed in very hot water. The house should also be vacuumed thoroughly. In addition to this, fingernails should be trimmed and the hands thoroughly cleansed. Each family member should use their own clean towel and washcloth. The above measures are necessary to rid the person and the home of pinworm eggs.



## POISONING

If your child should swallow an unusual substance, call your physician or poison control hotline immediately. It is best to have a bottle of Syrup of Ipecac on hand. *Do not use this medication, however, unless instructed to do so.* Please refer to the section on accident prevention on how to prevent poisoning in your child. **Northeast Arkansas Poison control Hotline number is 1-800-366-8888 (Missouri) or 1-800-376-4766 (Little Rock).**

## RASHES

**Newborn Rash:** Most rashes in newborns are entirely normal and are of no concern. Small white bumps on an infant's face and nose are called milia. These require no treatment. They will disappear in a month or so. Neonatal acne which resembles acne in older children occurs in infants due to maternal hormone stimulation. This, too, will fade with a little time. Birthmarks are common in babies, especially over the eyelids and over the back of the neck. These should be discussed at a routine office visit.

**Bruise-Like Rash:** Any purple or bruise-like rash which cannot be explained by simple bruising should be evaluated right away.

**Diaper Rash:** Diaper rashes are usually due to either irritation of the skin from a wet diaper (ammonia) or to a yeast infection in the diaper area. A yeast can grow on the skin in moist areas. When a diaper rash appears, try especially hard to keep the skin clean and dry. Change the diaper as soon as it is wet or soiled. It is a good idea to put zinc oxide ointment (Desitin) or Vaseline in those areas. If the rash is due to irritation from urine (ammonia), this treatment will be quite effective and the rash should resolve. However, if the rash does not improve with this treatment, contact your physician.

**Eczema:** Eczema is a skin condition seen in allergic people, which causes the skin to be dry and sensitive. Sometimes, this can lead to a rash over most of the body which is scaly, red, itchy and sometimes even broken open or weeping. Eczema tends to occur in people with a family history of allergy (asthma, hay-fever, eczema, and/or itchy, watery eyes). The treatment of eczema is primarily directed at keeping the skin well hydrated. To do this, it is recommended that the mildest and least amount of soap possible be used. Examples of mild soap are: Dove, Tone, Purpose and Neutrogena. Soap washes away the normal oils of the skin and makes eczema worse. In addition to this, applying Moisturel or Eucerin lotion to the affected skin to further seal the skin from continued water loss can be helpful. If your child's dry, sensitive skin continues to be a problem despite the above measures, you should contact your physician.

**Hives and Allergic Rashes:** Hives are red, raised rashes in various sizes, which are usually due to an allergic reaction. The rash seems to move to different areas of the child's body. It is often associated with itching and sometimes with swelling of the hands and feet. The rash is usually not dangerous, but can be uncomfortable. Hives can be caused by anything that the child has eaten, breathed or come in contact with. Hives are almost never due to something that is new in the diet. Usually, the child has been exposed to the very thing that caused the hives sometime in the past with no reaction.

The treatment of hives is to remove what is causing the rash and make the child comfortable. Of course, to remove what is causing the rash requires that it be identified, which can be very difficult. Write down everything that your child had to eat or was exposed to during the 24 hour period prior to the break-out of the rash. If the hives recur, this should be done again. With each episode, the list should be compared to try to identify the agent responsible.

Benadryl should be given to your child. This will help resolve the rash and control the itching (see Dosing Guide). If your child develops a breathing problem associated with this rash (very rare), the child should be seen immediately.

**Poison Ivy:** If your child has come in contact with poison ivy or another irritant, it is important to wash the involved area thoroughly with soap and water to remove the poison ivy toxin. You should treat poison ivy (contact dermatitis) with three types of treatment to speed healing and comfort the child. First, cortisone medicine is quite effective in decreasing the inflammation due to poison ivy. Over-the-counter, 0.5% hydrocortisone cream or ointment (Cortaid) can be helpful. If the rash is particularly severe, you should contact your physician. A stronger cortisone cream or ointment or an oral form of cortisone may be prescribed. Elixir can be used to control itching (see Dosing Guide). Lastly, Calamine lotion and Aveeno baths are sometimes helpful for itching. As with other rashes that cause itching, you should trim your child's nails to prevent scratching and scarring. You can not catch poison ivy by touching the rash of someone who has contracted poison ivy (contact dermatitis). Contact dermatitis is not contagious.

**Rashes Due to Drugs:** If a rash develops while your child is taking medication, the medication should be stopped and your physician notified. *See section on allergy in this booklet.*

**Seborrheic Dermatitis (cradle cap):** Cradle cap is a red, scaly rash on the scalp and body of newborns and infants. This is caused by excessively oily skin. The use of baby oils can make it worse. Seborrheic dermatitis (cradle cap) is treated by removing the scales with an anti-dandruff shampoo such as Sebulex and scrubbing with a soft baby brush. If the rash on the body is particularly severe or if the cradle cap does not resolve with the dandruff shampoo, contact your physician.

## **SEIZURES**

Seizures can be one of the most frightening events in a child's life for his/her parents. Most parents are afraid that their child will stop breathing and die during a seizure. This is almost never the case. If your child should have a seizure, place the child on his/her back or side and turn his/her head to the side to prevent choking on stomach contents in case of vomiting. The tongue should be protected as best you can. Your physician should be notified immediately and it may be recommended that your child then be taken to the nearest emergency room.

## **SLEEP PROBLEMS**

Sleep problems, and in particular, frequent night time awakenings are an extremely common frustration for parents of young children. Part of the answer lies in knowing what to expect from your child at certain ages. A newborn will average two awakenings a night, usually for a feeding and a diaper change. By 2 months of age, they are down to one arising or none at all, and by 4 months of age, a majority of infants sleep through the night. Acute illnesses, such as a bad cold or ear infection can temporarily upset your child's sleeping pattern. A 5-6 month baby who is not consistently sleeping a full night, or an older infant who develops night-time awakenings, is considered to be a self-trained poor sleeper, and therefore is also capable of being trained to sleep all night independently.

Unfortunately, the only method of any proven value in correcting poor sleepers involves allowing them to "cry it out" to some degree. Most young children who awaken in the night are simply hooked on a habit or association they require to get back to sleep (a bottle, rocking in your arms, etc.) and they are not too happy when those associations are broken. How do you do it? Put them in their crib awake; don't rock them to sleep in your arms. If they cry at that time, or as they awaken and fuss later in the night, allow 10-15 minutes waiting periods before you step in. When you do go in, stay only for a moment and don't get your baby out of the crib. The interval between each brief visit can be extended a little until your child drifts off to sleep. It will take an iron will and two to three nights for your infant's bad habit to budge, but the method usually works and most parents feel it was well worth the effort.

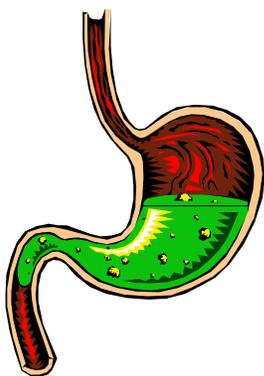
If you've tried this technique without progress, or if there are other unusual features about your infant's sleep patterns, be sure to bring up this issue at your child's next preventative care visit. A helpful book on children's sleep disorders is listed in the reference section.

## **SORE THROAT**

A mild sore throat without fever can be treated with warm salt-water gargles, throat lozenges, or Chloraseptic spray. If your child has a sore throat, which persists over several days, or if fever is present, a visit with your physician is recommended.

## SPITTING UP

A small amount of spitting up is common to most babies and should not be thought of as abnormal. It usually resolves with the first few months of infancy. If spitting up seems excessive, occurs with every feeding, or is more forceful, consult your child's physician. As long as he/she is growing and developing well, is not having choking episodes or turning blue, and is not excessively irritable, spitting up is more of a nuisance than it is dangerous. However, if any of these conditions are present, there are medications that can sometimes benefit an infant with this condition. Recurrent projectile vomiting (vomiting that shoots out of the mouth) is abnormal and requires a medical workup.



## STOMACH ACHE

Most minor stomachaches in children are not serious and require no treatment. You should contact your physician if your child should have a stomach ache associated with fever, pain in urination, persistent vomiting, or if the stomach ache is severe. Severe stomachaches associated with fever and anorexia (absolutely no appetite) are potentially serious. If your child has these symptoms, you should call your doctor.

## TEETH & TEETHING

Most babies cut their first tooth at around six months of age, however, there is considerable variation from child to child. Teething is a normal event in a child's life. It probably does not cause illness in children. Drooling and chewing are also normal around six months of age and these may be in part due to the discomfort of teething. In general, it is not recommended that you put salve or lotion on the baby's gum for teething symptoms. Acetaminophen (Tempra, Tylenol - see Dosage Guide) can be given for mild teething symptoms. Certainly any severe symptom such as fever, prolonged vomiting and irritability should never be assumed to be due to teething, but rather treat it as you would any illness in your baby. Probably the best advice to give for the child who is teething is to provide a cold pacifier or cold teething ring to bite on.



**Mouth Trauma:** Young children may take falls and often injure their mouths in the process. Bleeding after such a fall can be due to a tear of the frenulum, which is a small growth of skin between the lip and gum. Applying pressure to the gum will stop the bleeding in a few minutes and no other treatment is needed. If teeth are loosened or knocked out, consult your dentist. If a tooth is knocked out, you should put the tooth in a clean container and bring it to your dentist. Some teeth can be replaced.

## VOMITING

Vomiting or forceful emptying of the stomach happens when the stomach becomes irritated. This is usually caused by a viral infection, although there are other causes. When vomiting is due to a routine stomach virus, it is sometimes associated with diarrhea. The following treatment should be used for vomiting and/or diarrhea:

1. Give nothing by mouth for three or four hours after the last vomiting episode to rest the stomach, then begin to give fluids with frequent small sips gradually increasing the volume. If the vomiting persists for more than four hours, begin fluids (small sips) anyway, in between vomiting episodes. Much of this fluid can be absorbed even though the vomiting continues. If diarrhea alone is present, begin fluids as outlined below in large amounts.
2. Watch closely for signs of dehydration (see section on diarrhea and dehydration of this booklet).
3. For the first 24 hours, give:
  - no milk products
  - clear fluids in small amounts at room temperature and offer frequently
  - offer fluids such as:
    - Infalyte or Pedialyte - for infants
    - Kool-aid or Gatorade - above the age of 2 years
    - Jello, Jello water
    - Sprite or 7-Up
    - Ginger-ale
    - Pop-suckles
4. After 24 hours:
  - Offer bland foods if your child can tolerate these. These foods include:
    - Rice or cooked cereal (no margarine or butter)
    - Ripe bananas
    - Applesauce
    - Crackers or dry toast
5. After 48 hours:
  - As your child's appetite increases, offer foods such as:
    - Canned or cooked vegetables, apples, apricots, peaches, pears
    - Angel Food cake or plain cookies
    - Gelatin /gelatin desserts
    - Plain macaroni, spaghetti, noodles (no cheese or grease)
    - Rice or mashed potatoes
    - Baked or broiled chicken, fish or turkey
    - Bullion or chicken soup (no fat)

You should avoid milk or milk products, whole grain cereals or breads, raw fruits and vegetables, citrus fruits, red meats, greasy foods, and fried and spicy foods for five days after an episode of vomiting and/or diarrhea.

**You should contact your physician if:**

1. The vomiting persists for more than 12 hours.
2. Signs of dehydration are present (see section on diarrhea and dehydration).
3. Your child becomes confused or difficult to arouse.
4. The vomiting is associated with a severe headache.
5. Your child is less than two months old and is vomiting forcefully.
6. The vomiting is green stained (bilious).
7. Your child is unable to keep down clear liquids.

## APPENDIX

### Recommended Books on Child Care:

1. Caring For Your Baby and Young Child by the American Academy of Pediatrics.
2. The First Three Years of Life by Dr. Burton White.
3. Guide To Your Child's Sleep by George J. Cohen, M.D.

### Home Medications:

It is important to have your medicine cabinet well supplied to be able to effectively deal with illnesses and accidents when they occur. The following is a list of commonly used medications and supplies which you may find useful to keep on hand.

\* Keep all medication and/or potential poisons such as cleaners in locked cabinets out of reach of children.

1. **Acetaminophen** (Temptra, Tylenol) - This comes in several forms from drops to chewable tablets. It is used for pain and fever control.
2. **Ibuprofen** (Motrin, Children's Advil Suspension) - This medicine is an effective alternative at relieving fever. For older children and adults ibuprofen tablets (Nuprin, Advil) are available over-the-counter.
3. **Mycitracin, Polysporin Ointment** - This is used for treating cuts, scrapes and superficial skin infections.
4. **Syrup of Ipecac** - This medicine is used to induce vomiting (an emetic) in case of certain accidental poisonings. *It should only be used on the direct advice of a physician. Vomiting should not be induced for all types of poisonings. Please see the section on poisonings.*
5. **Benadryl** (Diphenhydramine) - This antihistamine medication is used for allergic reactions and itching.
6. **Infalyte or Pedialyte** - This carbohydrate and salt solution is used to treat vomiting and diarrhea in children.
7. The following health aids are useful: Band-aids, gauze 4X4's, thermometer, tweezers, scissors and white tape.

If your child has a history of chronic ear infection, you may want to keep **Auralgan Otic drops** (or equivalent) - These deaden ear pain when placed in the ear. If your child has ear tubes (pressure equalizing tubes) or has an ear infection with pus or blood draining from the ear, you should not use Auralgan, but should contact your physician.

## DOSING GUIDE

This Dosing Guide gives dosages for common over-the-counter medications used in children. These medications are dosed according to **weight**. To calculate your child's dose therefore, look up his **weight** on the Dosing Guide and read across to the proper dose for each medicine listed. If you don't know your child's weight and if your child is too young to stand on bathroom scales, a simple way to determine his weight is to first weigh both you and your child as you hold him. Then weigh yourself alone. Subtracting these two numbers will give you a fairly accurate weight of your child.

**Abbreviations:**

- mg = Milligram
- tsp = Teaspoon
- ml = milliliter
- cc = cubic centimeter
- dppr = dropper full
- 1 cc = 1 ml
- 1 tsp = 5 ml/5 cc



**ACETAMINOPHEN**  
(Tempra, Tylenol)

**Dosage:** Every Four Hours

**When to Use:** Acetaminophen should be used to reduce fever and relieve pain. Acetaminophen has no anti-inflammatory actions.

**Side Effects:** Unlike ibuprofen and aspirin which can have rare but potentially serious side effects, acetaminophen is very safe. Only if an overdose of the medication occurs is there a likelihood of any side effect. If your child takes an over-dose of acetaminophen call your physician or poison control center immediately.

Weight (estimated)	Maximum Dosage	Dosage Based on Children's Suspension 160 mg/1 tsp or 5ml	Dosage based on Chewable Tablets 80 mg/tablet	Dosage based on Junior Chewable Tablets 160mg/tablet	Dosage based on tablets 325 mg or 500 mg
10 lbs.	64 mg	2 ml	N/A	N/A	N/A
15 lbs.	96 mg	3 ml	N/A	N/A	N/A
20 lbs.	128 mg	4 ml	N/A	N/A	N/A
25 lbs.	160 mg	5 ml (1 tsp)	2 tablets	1 tablet	N/A
30 lbs.	192 mg	6 ml	2 tablets	1 tablet	N/A
35 lbs.	240 mg	7.5 ml (1.5 tsp)	3 tablets	N/A	N/A
40 lbs.	272 mg	8.5 ml	N/A	N/A	N/A
45 lbs.	288 mg	9 ml	4 tablets	2 tablets	N/A
50 lbs.	320 mg	10 ml (2 tsp)	4 tablets	2 tablets	1 tablet (325mg)
55 lbs.	352 mg	11 ml	4 tablets	2 tablets	1 tablet (325mg)
60 lbs.	400 mg	12.5 ml (2.5 tsp)	5 tablets	N/A	N/A
65 lbs.	448 mg	14 ml	6 tablets	3 tablets	N/A
70 lbs.	480 mg	15 ml (3 tsp)	6 tablets	3 tablets	N/A
75 lbs.	512 mg	16 ml	6 tablets	3 tablets	1 tablet (500mg)
95 lbs.	640 mg	20 ml (4 tsp)	8 tablets	4 tablets	2 tablets (325mg)

Children over the age of 12 years and adults may take two 325mg acetaminophen tablets.

**IBUPROFEN**  
(Motrin or Advil)

**Dosage:** Every 6-8 Hours

**When to Use:** Ibuprofen should be used to control high fevers which are unresponsive to acetaminophen. It can also be used to control pain and reduce inflammation.

**Side Effects:** May cause upset stomach, other side effects are rare.

**SHOULD NEVER BE ADMISTERED TO CHILDREN UNDER THE AGE OF 6 MONTHS.**

Weight (estimated)	Maximum Dosage	Dosage Based on Children's Suspension 100 mg/1tsp or 5ml	Dosage based on Ibuprofen tablets 200mg/tablet
15 lbs.	40 mg	2 ml	N/A
20 lbs.	60 mg	3 ml	N/A
25 lbs.	75 mg	3.75 ml	N/A
30 lbs.	90 mg	4 ml	N/A
35 lbs.	100 mg	5 ml (1 tsp)	N/A
40 lbs.	120 mg	6 ml	N/A
45 lbs.	125 mg	6.25 ml	N/A
50 lbs.	150 mg	7.5 ml (1.5 tsp)	N/A
55 lbs.	160 mg	8 ml	N/A
60 lbs.	180 mg	9 ml	N/A
65 lbs.	200 mg	10 ml (2 tsp)	1 tablet
70 lbs.	200 mg	10 ml (2 tsp)	1 tablet
75 lbs.	225 mg	11.25 ml	N/A
85 lbs.	250 mg	12.5 ml (2.5 tsp)	N/A
95 lbs.	300 mg	15 ml (3 tsp)	N/A

Children over the age of 12 years and adults may take ibuprofen tablets (200mg), two every 6-8 hours.