INFANT and CHILD CARE

RESTON TOWN CENTER PEDIATRICS

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Suite 205
Reston, Virginia 20190-3236

www.rtcpeds.com
(703) 435-3636
Revised 2023

IMPORTANT PHONE NUMBERS

Emergencies and Rescue Squad	**911**
Poison Control	**(800) 222-1222**

Main Office Line	(703) 435-3636

This includes:

- Advice line:
  weekdays 8:00am–12:30pm
  and 2:00pm–5:00pm
- Future appointments
- Referral requests
- Medication refills
- After-hours urgent call

Administrative Questions	(703) 435-0325
Billing	(703) 435-0726
Fax	(703) 435-9145

To ensure we can return your call, please deactivate any call-blocking features.

Reston Town Center Pediatrics
www.rtcpeds.com

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WELL-CHILD PROTOCOL

2–4 Weeks	Exam, Review routine newborn screening, Hep B (if not done at birth)
2 Months	Exam, Pentacel, PCV-13, Rotavirus, Hep B
4 Months	Exam, Pentacel, PCV-13, Rotavirus
6 Months	Exam, Pentacel, PCV-13, Rotavirus, Flu
9 Months	Exam, Anemia and lead screen, HepB
12 Months	Exam, MMR, Varicella, Hep A, Flu, Vision
15 Months	Exam, Pentacel, PCV-13, Flu
18 Months	Exam, Hep A, Flu
2 Years	Exam, TST, Lead, Flu, Vision
30 Months	Exam, Flu
3 Years	Exam, TST, Lead, Flu, Vision
4 Years	Exam, TST, Lead, Hearing, Vision, MMR-V, Flu
5 Years	Exam, Hearing, Vision, TST, Lead, DTaP, IPV, Flu
6 Years	Exam, Hearing, Vision, TST, Lead, Flu
7 Years	Exam, Flu, TST
8 Years	Exam, Hearing, Vision, TST, Flu
9 Years	Exam, Lipid panel, Flu, TST
10 Years	Exam, Hearing, Vision, Flu, TST
11 Years	Exam, MCV-4, Tdap, HPV, Flu, TST
12 Years	Exam, Hearing, Vision, Flu, TST
13–14 Years	Exam, Flu, TST
15 Years	Exam, Hearing, Vision, Flu, TST
16–17 Years	Exam, Lipid panel, MCV4, Flu, TST, Men B
18 Years	Exam, Hearing, Vision, Flu, TST

*

Autorefractor	Automated vision screen
DTaP	Diphtheria, Tetanus, and Acellular Pertussis
Flu	Influenza virus vaccine is offered yearly during flu season
Hearing	Audiogram Hearing Screen
HepA	Hepatitis A
HepB	Hepatitis B
Hib	Haemophilus influenza type B meningitis
HPV	Human papillomavirus | Gardasil
IPV	Inactivated Polio
Lead	Lead questionnaire
Lipid Panel	Cholesterol and triglyceride blood test (finger prick)
MCV-4	Meningococcal meningitis | Menactra
Men B	Meningococcal B meningitis vaccine | Trumenba
MMR	Measles, Mumps, Rubella
MMR-V	Measles, Mumps, Rubella, Varicella (chickenpox)
PCV-13	Pneumococcal meningitis
Pentacel	Combination vaccine with DTaP, IPV, and Hib
Rotavirus	Oral rotavirus vaccine (diarrheal illness)
Tdap	Tetanus, diphtheria, acelluar pertussis
TST	Tuberculosis screening questions
Vision	Developmentally appropriate vision screen
VZV	Varicella (chickenpox)

NOTE: Vaccine schedule may differ if your child has missed doses or is traveling internationally. Schedule is subject to change based on new recommendations and/or vaccine supply.

AN INTRODUCTION TO OUR OFFICE AND MEDICAL STAFF

We are pleased that you have selected us to provide quality pediatric and adolescent care for your child. We have written this booklet to give you information about our practice and to offer some basic child care guidelines that you may find helpful. Please keep it readily available for easy reference as you will find answers in these pages that may save you both worry and time.

Our practice is limited to the care of infants, children, and young adults through college age. You may select one health care provider for your child's care, or you may choose to see many providers. The choice is up to you. Occasionally, you may be unable to schedule a convenient appointment with the provider of your choice. In this event we encourage you to see another one of our providers. Over time you will have the opportunity to meet us all, which we hope will be to your benefit.

OUR MEDICAL STAFF

***HOPE TAYLOR SCOTT*, MD, FAAP,** received her undergraduate degree from Cornell University and her medical degree from George Washington University School of Medicine. Dr. Scott completed her residency and was chief resident at Georgetown University Hospital prior to entering private practice at Reston Town Center Pediatrics in 1989. She became board certified in pediatrics in 1989 and is a Fellow of the American Academy of Pediatrics. In 2004, she earned an additional board certification in developmental-behavioral pediatrics.

***MICHELLE S. SUSCO*, MD, FAAP,** received her undergraduate degree from Canisius College and her medical degree from the State University of New York at Buffalo School of Medicine and Biomedical Sciences. Dr. Susco completed her residency in pediatrics at Children's National Medical Center. She became board certified in pediatrics in 1994 and is a Fellow of the American Academy of Pediatrics. After residency, she practiced at Child Health Care of Manassas for 5 years prior to joining Reston Town Center Pediatrics in 1999.

***SUZANNE M. POWERS*, MD, FAAP,** received her undergraduate degree from Virginia Tech and her medical degree from Indiana University School of Medicine. Dr. Powers completed her residency in pediatrics at University of Arizona Health and Sciences Center. She became board certified in pediatrics in 2001 and is a Fellow of the American Academy of Pediatrics. After residency, she practiced at the Family Health Center of Battle Creek, Michigan, for several years prior to joining Reston Town Center Pediatrics in 2004.

***JACLYN FLEMING*, DO, FAAP,** received her undergraduate degree in psychology from The George Washington University. Before starting medical school, Dr. Fleming spent several years in the field of psychiatric research, where she has numerous publications. In 2009, she decided to pursue her lifelong dream of becoming a physician and received her medical degree from the Virginia College of Osteopathic Medicine in Blacksburg, Virginia. After completing her pediatric residency at Inova

Fairfax Hospital, she became board certified in pediatrics in 2016. She is a Fellow of the American Academy of Pediatrics.

***MUTSA NYAKABAU*, MD, FAAP,** is a native of Harare, Zimbabwe, who moved to the United States in 2005 to further his education. Dr. Nyakabau attended George Mason University, where he ran track and field and studied biology. He then pursued a combined MD/MPH degree through Georgetown University School of Medicine and the Johns Hopkins Bloomberg School of Public Health. He completed his residency at the Geisinger Health System in Pennsylvania, after which he helped to establish a pediatric and pediatric behavioral health program at Family Healthcare of Hagerstown in Maryland. He joins Reston Town Center Pediatrics with a passion for teaching.

***JESSICA HOWARD,* DO, FAAP,** received her undergraduate degree from Virginia Tech and remained in Blacksburg to get her medical degree from the Virginia College of Osteopathic Medicine. Dr. Howard then completed her pediatric residency at Inova Fairfax Hospital. She became board certified in 2013 and is a Fellow of the American Academy of Pediatrics. Prior to joining Reston Town Center Pediatrics, Dr. Howard worked as a pediatrician in Maryland for 9 years. She has received additional training as an advanced lactation specialist to provide better support for moms and babies with breastfeeding difficulties. Additionally, as a Red Cross Blood Program Leader, she is passionate about the importance of blood donation and helps organize blood drives (and donates a lot of blood herself).

Our staff includes five highly trained nurse practitioners who work in close association with our physicians and are available to see your child for both well and sick visits:

***NANCY A. DARMORY*, RN, MSN, CPNP, IBCLC,** received her undergraduate degree from Villanova University. She served as an army nurse for several years, working in various locations and settings. Most of her time was spent on pediatric oncology units, the pediatric intensive care unit, and the emergency department. She completed her master's degree in nursing and lactation consultant education at The Catholic University of America. She became a certified pediatric nurse practitioner and lactation consultant in 2000, and then entered private practice.

***KATHERINE MAJOR MCHUGH*, RN, MSN, CPNP,** earned her undergraduate degree at James Madison University and her bachelor and master of nursing at the University of Virginia. She worked as a nurse in the pediatric intensive care unit at Inova Fairfax Hospital for 5 years before entering private practice in 2013.

***AMY BROZICK JACOBSON*, RN, MSN, CPNP,** earned her bachelor of science in nursing at Duquesne University and her master of science in nursing at the University of Virginia. Prior to becoming a nurse practitioner, she spent 8 years as a registered nurse in a neonatal intensive care unit. She entered private practice as a certified pediatric nurse practitioner in 2014.

***BRITTANY ADAMS,* RN, MSN, PNP-BC,** received her undergraduate degree in nursing at Xavier University in Cincinnati, Ohio, and her graduate degree in

nursing at Georgetown University. She has worked in a variety of community health care settings in the Greater Washington D.C. and Northern Virginia region with a focus on underserved and vulnerable populations. She became a certified family nurse practitioner and entered primary care in 2012.

***HEATHER KUHLMAN*, RN, MSN, FNP-C,** received her bachelor's degree in psychology with a focus in children and family counseling from North Carolina State University, her associate's degree in nursing from Tacoma Community College, her bachelor's degree in nursing from George Mason University, and her master of science in nursing as a family nurse practitioner from The George Washington University. She has more than 14 years of nursing experience in cardiac and postanesthesia care units, labor and delivery, pediatrics, school nursing, and family practice in Washington State and Virginia, as well as in Africa at The International School of Uganda and in refugee clinics in Kampala, Uganda, and in Vicenza, Italy, for the U.S. Army Medical Command. She has specialty training as a sexual assault forensic examiner, and is certified as a breastfeeding specialist/lactation counselor and as a basic life support instructor.

Our (amazing) lactation consultant:

***MARY BRIGHT*, LPN,** obtained her nursing diploma from Chesapeake School of Nursing in 1971 and her lactation certification from Georgetown University Hospital in 1993. Mary has 40 years of experience in lactation!

USEFUL OFFICE INFORMATION

CONTACT US

Our office hours are 9:00am–12:30pm and 1:30pm–5:00pm, Monday to Friday, by appointment. **You may make appointments online at www.rtcpeds.com or by phone at (703) 435-3636. If you unable to keep an appointment, please notify us 24 hours in advance to avoid cancellation fees and provide appointment space for other patients. If you are more than 15 minutes late for your appointment, as a courtesy to other patients, we reserve the right to reschedule your appointment.** This policy allows our office to run as smoothly as possible. On occasion, patient care emergencies may cause delays on our part; whenever possible, we will notify you about such situations.

WALK-IN MINOR ILLNESS CLINIC

This clinic is available Mondays *and* Fridays, 8–9am. Patients over 6 months of age with symptoms lasting less than 1 week can be seen on a first-come, first-served basis. Examples of minor illnesses are fevers, ear pain, sore throat, cough, vomiting, diarrhea, acute asthma, or wheezing.

SATURDAY APPOINTMENTS

On Saturdays, our clinic is available by appointment for minor illnesses as described above. Please call between 8am and 10am on a Saturday and leave a message on the after-hours line. One of our nurses will call you back to offer guidance and make an appointment if necessary.

Advice and Help Line

We are more than happy to assist you with medical concerns by phone or through our website. Many worrisome questions can be answered by our trained nursing staff, which may save you an office visit. Visit www.rtcpeds.com or call the nurse line, (703) 435-3636, weekdays, 8:00–12:30pm and 2–5pm, to address problems such as medication refills or your child's other medical needs. You may also schedule a same-day appointment, if needed. If the nurse cannot satisfy your inquiry, a message will be passed to your provider who will return your call at the earliest opportunity.

Same-Day Appointments

If you are calling to make an appointment for a sick visit, we recommend that you call (703) 435-3636 before 3:30pm to enable us to make an appointment on the same day.

Future Appointments

To make future appointments, visit www.rtcpeds.com or call (703) 435-3636 after 10:00am when the phones are less busy.

When making an appointment, please inform the nurse of all the concerns you would like to address so that adequate time can be scheduled for your visit.

Prescription and Refill Requests

All prescriptions and refills, including ADHD/ADD medications, should be requested through our patient portal or by phone during normal office hours (Monday–Friday, 9:00am–5:00pm). Please call (703) 435-3636 and leave the requested information. We must have at least a 24-hour notice but recommend a 3-day notice.

Laboratory and Medical Testing Results

Most laboratory results are received and reviewed by the providers within 48–96 hours. However, please note that some tests take more time. It is our office policy to notify patients of any significant results. Please ensure that our office has updated and accurate contact information. Most lab results are posted on our patient portal after they are reviewed by the provider who ordered them.

Emergencies and After-Hour Calls

In the event of a life-threatening emergency please call 911. In the event of an accidental ingestion, call the **National Poison Control Center at (800) 222-1222.** If you go to the emergency department to address a concern, please inform them that you are a patient of Reston Town Center Pediatrics. We recommend that you familiarize yourself with your insurance and any restrictions on emergency department use.

After hours, call us at (703) 435-3636 or (703) 437-9699. Your call will be answered within 60–90 minutes by an experienced pediatric advice nurse who will provide you with guidance and contact one of our physicians if necessary. There is a charge for all after-hours calls.

Please ensure your phone is able to receive calls (for example, ringer is on, phone is not in sleep mode). Note that we are unable to return phone calls after hours to

phones that have anonymous-call blocking. Deactivate this feature by dialing *87. After the call is completed, you may reactivate anonymous-call blocking by dialing *77.

Please remember: for any emergencies you must call 911.

WALK-IN OR URGENT CARE CENTERS

Many patients ask us our opinion on urgent care, walk-in, or “minute” clinics. These types of clinics may be convenient in certain situations. However, please note that we will do our best to accommodate you, provide continuity, and address the global health of your child. If you choose to visit a minute clinic or urgent care, we urge you to ensure that you are seeing someone skilled in pediatric care. If you have questions or concerns about these types of clinics, please feel free to discuss with one of our providers.

FINANCIAL POLICIES

We ask that before making your first appointment you contact your insurance company to verify that we are a preferred provider with your plan. You may need to designate Reston Town Center Pediatrics as your primary care provider prior to your visit. If you have a co-payment, you are contractually obligated to pay it at each visit. If your insurance plan does not pay for all services, you will be responsible to pay for the remainder of the charge within 30 days. Each plan varies and details can be complicated. Please familiarize yourself with your insurance benefits.

If our office does not participate with your insurance plan, it is our office policy to collect payment in full at the time services are rendered. We will provide you with a receipt to submit with your insurance claim form.

Cancellations: There is a charge for missed appointments. To avoid a missed appointment charge, *we request a 24-hour notice for a cancellation.*

If serious financial difficulties arise for your family, contact our office manager to discuss personalized payment options.

For your convenience we can keep a credit card on file. We accept Visa, Mastercard, Discover, and American Express. Additionally, we take check and cash, and we have online and mobile payment options. There will be a charge for returned checks.

WAITING ROOMS

We have 3 waiting rooms: one for sick children, one for well children, and one for adolescents. To reduce your child’s risk of infection, we no longer supply books or toys in the waiting rooms. Please feel free to bring toys, books, or games to entertain your child safely while waiting. We do have coloring sheets and crayons; just ask if you need them.

PART 1 - THE NEWBORN PERIOD

Congratulations! The birth of your infant is an exciting and challenging time. Relax and enjoy this experience and trust your own common sense to guide

you. Remember, your infant is an individual unlike any other, so do not expect him or her to follow “the book” entirely.

We have prepared this booklet in anticipation of some of your questions, and it is by no means complete. We do hope that you will find it a helpful resource.

Please note, for the purposes of this booklet, we have arbitrarily chosen feminine pronouns. However, the guidance provided is applicable to all children.

BATHING

Until the umbilical cord area and circumcision are healed, your baby should have only sponge baths. Afterward, the baby may be propped up in a small tub of warm water.

Choose a warm area so that your infant will not get too cold. Have all your bath needs within your reach so that you never leave your child unattended. While in or near water, your infant should be *always within arm’s reach*.

Bath time should be an enjoyable and relaxing time for both of you. Initially your infant may cry with her baths, but by 3 months of age she should be enjoying it, splashing and playing in the water. Bathing two to three times a week is adequate, but you may bathe your infant more often if you desire. Soaps or shampoos are not necessary. If you choose to use them, choose a gentle cleanser, free of dyes or fragrances. Lotions are also not necessary in most cases. They too may contain perfumes and additives, which can cause skin irritations. Your baby smells good just the way she is. A small application of petroleum jelly or other lubricating ointment in the diaper area will help protect her skin if needed. We discourage the use of powders as they can be inhaled or cake up and harden.

BE PREPARED

Listed below are some handy items you may want to have at home:

- Petroleum jelly or similar ointments for various baby rashes
- Diphenhydramine (Benadryl) liquid for babies, chewables or tablets for older kids
- Acetaminophen (Tylenol) liquid for babies, chewables or tablets for older kids
- Ibuprofen (Motrin, Advil) liquid for babies, chewables or tablets for older kids
- Hydrocortisone 1% over-the-counter ointment
- Gauze
- Bandages/Band-Aids
- Alcohol or other disinfectant, such as hydrogen peroxide
- Neosporin

BREAST TISSUE

Due to maternal hormones, breast enlargement is common in all babies after birth, even boys! This enlargement will diminish gradually but may be prolonged in the breastfed infant. Your infant's breasts should never look red, be tender, or

suddenly enlarge. If this occurs, call us.

CORD CARE

Your baby's umbilical cord may dry and fall off during the first 1–2 weeks of life, but this may take as long as 8 weeks. The area at the base of the cord should be left alone. Try to fold the diaper down away from the umbilical cord until the cord falls off. It is not uncommon to notice a few drops of blood or mucus on the navel after the cord falls off. Apply pressure and the bleeding will stop. If there is persistent bleeding or drainage, please call us.

CRYING AND COLIC

Crying is a normal mode of expression for all babies. In a very short period of time, you will be able to interpret what your baby is trying to tell you. It is important to remember that not all crying signifies hunger. Some babies need less stimulation, and some are asking for more. They may be wet, tired, wanting to suckle, wanting to be held, or feeling too cold or too hot. At times you will find that nothing you do relieves her irritability. This usually occurs late in the afternoon and lasts for about 2–3 hours.

The term *colic* is used to describe prolonged, intense episodes of crying or fussiness for which often no satisfactory reason can be found. Colic usually begins in the second week of life, peaks at 2–3 months of age, and usually subsides by 4–6 months. There are many proposed causes and remedies—none of which work for all babies. Please feel free to discuss methods for addressing colic or fussiness with your provider. Some methods for soothing babies are listed below.

- Wrap your baby snugly in a blanket
- Use a sling, wrap, or front carrier to wear your baby
- Gently hold and rock or walk with your baby
- Try a pacifier
- Play white noise
- Try different positions for holding your baby

It is normal for you to feel frustrated, anxious, and angry, and even to blame yourself for not being able to always comfort your child. ***Never shake your baby.*** Remember that infant fussiness is common and so is parental frustration. Crying is a normal form of expression for your baby. It is important that you and other family members share caring for your infant so that you all can get some relief from the stress of caring for a colicky baby. It is also important that you get some time alone away from the baby. Ask a partner, relative, friend, neighbor, or babysitter to watch the baby while you take a break. In the long run you will be happier and more rested. Both you and your baby will appreciate this!

If you would like to further discuss your child's behavior, please call us for an appointment.

ENVIRONMENT AND CLOTHING

Temperature: Keep your home at a comfortable temperature. Use how you dress yourself as a guide for how to dress your baby. If you are comfortable in a t-shirt and shorts, dress your baby lightly. If you are in long pants and a sweater, dress the baby in a full-length, warm outfit. Babies get hot in warm weather and cold in cool weather, as you do. To lower the risk for sudden unexpected death in infancy (SUDI), it is recommended that your baby is not too warm during sleep. Your baby should not be over-bundled or wear a hat during sleep.

Environmental stimulation: Your baby will like bright colors. A mobile may also stimulate your infant to focus on and follow movement after about 1 month of age. Babies love to look at faces, especially after about 2 months of age. It is always healthy to look at your baby and talk to your baby.

Noise: There is no need to tiptoe around and talk quietly when your newborn is sleeping. Most infants will sleep even while you vacuum in the same room. If your baby becomes used to a very quiet house, she may begin to wake up at the slightest noise.

Clothing: Cotton clothing is least likely to cause skin reactions. Wash all new clothes and blankets before using them for the first time. Some babies with more sensitive skin may require a hypoallergenic laundry soap, without dyes or fragrances.

Sun exposure: Please see the sun safety section in Part 2.

Screens: Screen exposure is not recommended for children 2 years or younger. Screen exposure may alter brain development and may increase risk for problems in school.

Insect bites: Protect your infant from insect bites by using a net over her stroller, especially when mosquitoes are at their worst, during summer twilight hours.

Air pollution: If air pollution is at dangerously high levels (code red alert days), avoid excessive time outdoors.

Smoking: Having a baby is an excellent incentive to stop smoking. We urge you to seize the opportunity and quit, for the baby and for you. Breathing in smoke increases a baby's risk for asthma, respiratory infections, lung problems, ear infections, and SUDI. If someone is smoking and will be around the baby, you can ask them to smoke outside, away from the baby. To remove toxic residues after smoking, it may help to remove top layers of clothing and wash hands and face prior to handling the baby. Babies spend a fair amount of time in the car, so it is important to keep both the home and car smoke free. Do not allow anyone to smoke around your baby! She depends on you to protect her delicate and developing lungs from smoke.

Tummy time: We suggest infants spend some time on their tummies as early as the first few days of life. It can be as little as a few minutes just a few times a day,

and should be done in the presence of an attentive adult. This helps babies develop strength, and it prevents flattening of the backs of their heads.

FEEDING | BREASTFEEDING

We encourage you to nurse your baby. Breastfeeding can and should be an enjoyable, rewarding, and successful experience with many health and emotional benefits for both you and your infant. Our lactation consultants are here to help you optimize your nursing experience.

Human milk contains sugars, protein, fat, and micronutrients your baby needs to grow. It also contains many substances to improve your baby's overall health, such as antibodies, immune factors, enzymes, prebiotics, probiotics, and white blood cells, which are believed to strengthen and shape your baby's immune system. This protection lasts for the duration of breastfeeding and long after your baby has weaned.

In the beginning, you can expect to feed your baby 8–12 times per day. As your baby grows, she may feed less frequently. You may discuss feeding schedules with our lactation consultants or with your provider.

The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first 6 months of life. After the introduction of solid foods, it is recommended that breastfeeding be continued for at least the first year of life and then beyond for as long as mutually desired by mother and child. Some organizations recommend breastfeeding until 2 years of age.

Though breastfeeding may seem like a lot of work at first, it is often easier once it is well established, and we are here to help. Partners and other family members can also support breastfeeding and participate in many ways. For example, if a mother chooses to pump, others can help feed the baby from a bottle.

Our practice offers lactation services to our patients to ensure the best possible breastfeeding experience. In fact, many of our mothers and babies go on to breastfeed well past the first year. Our International Board-Certified Lactation Consultants (IBCLCs) are available for in-office appointments and for phone advice.

FEEDING | BOTTLE FEEDING

Parents may feel that bottle feeding is the right choice for their family. Bottle feeding allows for partners and family members to feed the baby and to share in the night feedings. For some parents, it is comforting to know exactly how much their baby is getting with each feeding. For some mothers, breastfeeding is not an option, or they simply wish not to do it.

Formula provides sugars, protein, fat, and micronutrients your baby needs to grow and thrive. Though formula does not contain the exact components that are present in human milk, many formulas now more closely mimic breast milk. You

can discuss formula options with your provider.

Prepared formulas can be purchased ready-to-feed or powdered (1 scoop of powder formula to 2 oz of water). We recommend ready-to-feed formula for the first 2 months of life and then powdered formula. Note that this concern is *not* due to water safety concerns; rather, it is due to a susceptibility to infection *from the powder* in early newborns.

Ready-to-feed formula is the most convenient but also most expensive option. Powdered formula has many advantages. It is the most economical and the most portable. If you are concerned about the safety of your water, you may use bottled water or you may boil the water. Boil for 1 minute only, and then allow it to cool prior to preparing the formula. Using tap water or filtered tap water is generally safe.

Feedings are meant to be an enjoyable time for you and your baby. Feeding time is a time for you and your baby to relax and learn about each other. Feed your baby in a position that allows you to comfortably hold her in a semi-upright position. Hold the bottle so the nipple is always filled with milk. This helps prevent air from getting into the stomach. A semi-upright position will decrease the incidence of choking. Propping the bottle rather that holding it and feeding your baby increases the incidence of choking. *Do not prop bottles.*

The amount of formula your baby will take per feeding will vary from baby to baby and certainly fluctuate as she grows. As a general guideline, during the first month, babies will take between 2 and 4 ounces every 2–4 hours. By 6 months, a formula-fed baby will take between 6 and 8 ounces at every feeding and take 4–5 bottles in a 24-hour period. Most babies should take no more than 32 ounces of formula in a 24-hour period. If your baby seems to regularly want more, please discuss this with your provider.

Night feedings are tiring, especially if you have older children at home. Ask your partner to share some of these night feedings if you are not nursing. Try to rest and nap during the day. Once your baby weighs more than 12 pounds and is between 2 and 4 months of age, she might be capable of going through the night without a feeding. Because she can consume more during the day, she is able to take in all her calories during the day. If she still seems to feed very frequently or consume larger amounts, try distracting her. Research has shown that some patterns of obesity begin during infancy, so it is important not to overfeed your baby.

This is a general guideline, and each individual baby will regulate her intake depending on her activity level and growth rate. Let your baby tell you when she is hungry. She will usually establish her own schedule during the first few weeks. Babies, like adults, will often vary their intake from day to day and feeding to feeding.

Bottles, nipples, and bottles parts may be cleaned in the dishwasher or with hot soapy water and rinsed and allowed to dry thoroughly. Check the nipples regularly to make sure the silicone or plastic is not breaking down and the milk

flows through the nipple.

FEEDING | ADVANCING THE DIET

Starting your infant on solid foods should be an enjoyable experience. It is recommended that you wait until 4–6 months of age to begin solids. Discuss with your provider the best timing for you to introduce solids to your baby. Contrary to popular belief, feeding solids will not make your baby sleep through the night any sooner, and starting solids prior to age 4 months has been linked to obesity.

There is no right or wrong way to introduce foods to your baby. We offer some general recommendations that seem to work well for many babies. Remember, as your infant increases her solid intake, milk intake will naturally decrease.

We recommend introducing one new food every 2–3 days to allow your baby's gut to acclimate to new substances. Also, if your child has a reaction to a food, you can better determine the cause. If you are concerned about food allergy or have a family history of food allergy, you may discuss this with your provider. In general, avoiding allergenic foods such as nuts and eggs is *not* recommended. In fact, earlier introduction of foods may protect your child from allergies. This has been most studied with peanuts.

Many people like to start with vegetables since babies tend to prefer sweet foods. However, you can start in any order you feel comfortable. You may start with any pureed food, like grains (oatmeal, whole wheat), avocado, veggies (sweet potatoes, squash), fruit (bananas), legumes (lentils or beans), meats, or cereals.

Please make sure to include iron-rich foods, such as meats, beans, lentils, and dark leafy greens. Iron is essential for your baby's brain development. We prefer the above iron-rich foods over commercially prepared iron-fortified baby cereals or iron supplements.

Generally, parents start feeding with a spoon. Do not mix food or cereal in a bottle (unless instructed by your provider). It is not unusual for your baby to take only 1–2 teaspoons of pureed food in the beginning. As your baby begins to enjoy solids and swallows well, you may increase the amount and thicken the consistency. Infants generally take between 2 and 4 tablespoons of purees per feeding, but let your child's appetite and interest be your guide.

Once your child is eating baby food well and able to sit up well without support, allow her to try to feed herself finger foods, such as small pieces of avocado or steamed sweet potato. When she can accurately get them into her own mouth unaided, she is ready for finger foods.

Choose soft foods that she can mash with her gums and cut them into irregular pieces about the size of a pea to prevent choking. The presence or

absence of teeth does not matter; your baby can mash soft foods quite well with her gums. If you can mash the food between your thumb and forefinger, it is soft enough to feed to your baby. You may start exposing your baby to foods from your own plate now if it is manageable for your baby.

There is no absolute set time at which additional meals are added to your child's eating schedule. Instead, observe her development for clues as to when she is ready for more food. As your child becomes more competent and eager to eat (she anticipates the food by widening mouth and eyes and keeps at least half of the spoonful of food in her mouth), you may add more meals throughout the day. Most infants are eating three meals a day by 9 months of age.

If you give your baby meats, we recommend using real meat from your own table rather than baby food meat. You must ensure it is well cooked and properly stored according to safe food handling guidelines. As with other table foods, make sure it is soft and diced small to prevent choking. Note that preserved meats—such as hot dogs, luncheon meats, bacon, ham, and sausages—are high in fat, salt, and preservatives, and are associated with health problems in adults. Nitrate-free meats may be less preserved.

At around 1 year of age, give your child age-appropriate utensils to practice using a spoon and fork. She will probably still need your help with eating. You can also offer more finger foods.

By the time your baby is 1 year old, she should be eating about 3 meals and occasionally 2–3 snacks a day. This should include a balance of fruits, vegetables, healthy fats, protein, and whole grains. After her first birthday, if she is no longer nursing, 16–20 ounces of whole milk per day is sufficient. Most children will be eating table foods by now and can even be eating the same foods (maybe mashed or chopped up) as you! This is a good incentive for parents to eat healthy. Family meals are a great way to bond and to maintain healthy lifestyles.

Remember!

- Avoid anything your child may choke on. You should never give whole nuts, seeds, raw carrots, raw celery, uncut hot dogs, candy, uncut grapes, popcorn, or any small hard food that can cause choking. Always observe your infant when she is eating to ensure she is comfortable and safe.
- Train or refresh your training in the Heimlich maneuver for adults and infants. The American Heart Association, Mayo Clinic, and https://heimlichheroes.com/ are a few teaching resources.
- Avoid honey until age 1 year.

Making your own baby food: You may certainly make your own baby food. Choose healthy foods, including fruits, vegetables, grains, legumes, and tender

cuts of meat. Thoroughly rinse fruits and vegetables and remove any seeds and stem. Steam your produce until it is soft enough to mash. For meats, bake or cook the meat on a stove-top until it is well-cooked (usually 175 degrees). Cut the food into squares and use a food processor or immersion blender to puree it. Homemade foods given before 6 months of age should be strained or sieved before feeding to your baby. There is no need to add sugar, salt, or strong seasonings. You can freeze the food in ice cube trays and defrost it in the refrigerator or microwave oven when you are ready to use it.

Juices: In general, children do not need juice. They should be getting adequate fruits and vegetables from their diet. Juice is not a healthy alternative to fruit.

Baby-led weaning: For those parents interested in baby-led weaning, we are happy to support you and offer guidance. Please let us know if this is your preference.

The picky eater: Do not become disheartened if your child becomes picky about eating. Your baby may become fiercely independent about feeding. This is very normal! Offer your child finger foods so that she may feed herself. Make sure you maintain healthy options!

Try to avoid engaging your toddler in a battle over food. Accept the mess on the floor—it is part of the process. Continue to offer healthy options multiple times a day. Toddlers may need 5–6 “meals” or snacks a day, and the amount they eat may vary from day to day. Avoid salty snacks, highly concentrated sweets (such as cookies, juice, or soda), and caffeine. Studies show it may take 12 or more exposures to a new food for a child to acquire a taste for it, so keep on offering those healthy options. Offering or withholding food, especially sweets and desserts, should not be used as reward or punishment.

Check out www.doctorangel.com for more on food, nutrition, and recipes.

FLUORIDE AND DENTAL CARE

Fluoride is important for strengthening tooth enamel against cavities. Your child’s primary source of fluoride is the water she drinks. Our local public water supply is fluoridated. But if your tap water at home comes from a private well, your child may need a fluoride supplement beginning at 6 months of age. If you are using bottled water, you can purchase water that contains fluoride (tap/city water is preferred over bottled water). For children who spend most of the day away from home at daycare or school, the fluoride content of that water should be considered before starting fluoride supplementation. Please ask your dentist or one of our providers if fluoride supplementation is advisable for your child.

Prior to tooth eruption, you may wipe down your baby’s gums with a washcloth before bedtime.

You can start brushing your infant’s teeth at least once a day as soon as the first tooth erupts. You should use regular toothpaste *with fluoride*: use a very small

smear of toothpaste, the size of a rice grain. You may choose to use fluoride-free toothpaste as well, until your child learns to spit out the paste. You can also floss between any two teeth that are touching each other.

To further your child's dental health, we recommend eliminating bottle use by 12–18 months and avoiding sugary snacks and beverages. Children should never be put to bed with a bottle. This can cause cavities and result in choking.

The AAP recommends that children have their first visit with a pediatric dentist at age 1 year or with their first tooth eruption. If your child is not at risk for caries, you can discuss with one of our providers delaying the first dental visit until age 2 or 3 years. We offer fluoride varnish with well visits beginning at age 1 year.

GENITALIA

The genitalia of both boys and girls are often swollen after birth.

Girls: Infant girls often have a thick, white, cloudy discharge for several weeks after birth. Some female infants may have a bloody discharge, which is related to maternal hormones. This is normal. Your daughter's labia should be gently cleansed, from front to back, but you need not scrub away all the thick discharge.

Uncircumcised boys: In uncircumcised males, the foreskin is still adhered to the glans, or tip, of the penis. Do not force the foreskin back as it may scar and tighten. The foreskin will gradually become retractable on its own over a period of several months to years. Once the foreskin is retractable, often by age 4 or 5, you may gently slide the foreskin back and wash. This is often not necessary since boys will usually do this themselves.

Circumcised boys: If your son has been circumcised, you may apply petroleum jelly on any raw or pink areas to keep the healing tissue from sticking to the diaper. The urethral opening should not be blocked by the ointment. Do not be alarmed if the healing circumcision takes on a yellow-green color in patches. These are merely well-hydrated scabs. After the skin has healed, keep the area clean with soap and water. When well healed, gently slide the skin back as far as it will easily go and wash every day. Do not tug or force the foreskin as this may make it scar and attach to the penis. Small amounts of the foreskin may still be adhered to the head of the penis after the circumcision. Just as with the uncircumcised penis, this will correct itself over several months to years.

GROWTH AND DEVELOPMENT

An infant usually gains about 5–7 ounces per week or 1½ –2 pounds per month. Her length will increase by 1–2 inches per month in the first 6 months and then ½–1 inch per month. In general, babies double their birth weight by 4–5 months of age and triple it by 1 year of age. This growth occurs smoothly and reflects your baby's genetic inheritance as well as her own personal characteristics.

As you observe your baby's developmental milestones, keep in mind that it is not unusual for some infants to develop faster in certain areas and slower in others.

You will notice that your newborn tends to keep her hands fisted and her knees tucked under her stomach. She also has little head control initially and will need support for her head and back. You may notice that she likes to raise her head when you are holding her against your chest or when she is on her stomach. She likes to be cuddled and held closely. She knows that her parents provide peace and comfort. She develops a sense of trust that her needs will be met.

During the first 2 months, your child will be able to focus on objects approximately 8 inches from her face. Brightness, movement, and contrast, as well as three-dimensional objects will attract her. For instance, your facial features up close will be very interesting to your new baby! Bright-colored mobiles and pictures by the crib will also attract her attention.

An infant's hearing is essentially the same as adult hearing. You baby may startle when exposed to loud, sudden noise, but she will enjoy listening to music or your voice singing. Most noises will not disrupt a sleeping infant.

Let your baby kick without any clothes on and gently stroke her, moving her arms and legs, encouraging her to relax and gain a sense of her own body. Your baby will take great delight when you hold, rock, sing, and read to her. Child development specialists are increasingly aware of the crucial role that daily reading plays in the development of a child's intellect even from birth. Try to read to your little one for 10–20 minutes a day. The earlier you start reading to your baby the better.

We closely monitor your baby at each checkup to ensure that she is reaching developmental milestones appropriately. At each visit you will receive information on normal growth and development, including what you may expect your baby to be doing and how you can enhance your interactions with your baby. We also conduct routine screening for autism and developmental delays. Development is obviously a huge topic that cannot be completely addressed in this booklet, but below are a few examples of some typical milestones.

Birth–1 Month	• Startles • Keeps hands tightly fisted • Focuses 8–12 inches • Takes an interest in faces • At 1 month may focus on an object 3 feet away, briefly • Hearing is the same as an adult's • Recognizes familiar voices
2 Months	• Smiles • May start cooing • Fixates on a face

3–5 Months	• Raises head and chest when lying on stomach • Hands more loosely held • May like to bear weight on legs • Reaches for objects • Holds and plays with toys • Sees in color and follows moving objects • Recognizes familiar objects and people at more of a distance • Turns towards voices and smiles at you • Babbles and starts to imitate sounds • Turns head toward direction of sound • May roll
6–7 Months	• Rolls both ways (front to back and back to front) • Sits with support (eventually without) • Supports weight on legs • Brings hands together and may transfer hand to hand • Grasps in a raking fashion • Develops full color vision and improves tracking • Responds to name and sounds by making sounds • Starts to distinguish emotions by tone of voice • Babbles consonants • May try to find a partially hidden object • Uses hands and mouth to explore objects • Attempts to get objects out of reach
7–9 Months	• Visual pursuit of dropped objects • Listens to conversations and singing • Accepts two objects • Starts thumb–forefinger grasp • Sits without support • Babbling continues • May develop stranger anxiety
11–12 Months	• Reaches accurately for something as she turns away • Babbles unintelligible words • May say recognizable words • Points with index finger at desired object • Pulls up to standing position • Walks with support
13–15 Months	• Looks at an item you point at • Waves bye-bye • Responds to her name, most times • Says *dada* or *mama* for the correct person • Walks independently

16–18 Months	• Brings things to show you • Points to a few body parts when asked • Follows a simple request
19–24 Months	• Follows simple 2-step commands • At least 50% of speech is understood by strangers • Says several 2-word phrases • Identifies some pictures in books by name • Engages in pretend play (tea party, house) • Runs

HICCUPS

Hiccups are caused by swallowed air. They are normal and, even though intense, will not harm your baby. Nothing needs to be done to treat hiccups.

ILLNESSES

There are several steps that you can take to avoid illness during the vulnerable first 6–8 weeks of your baby's life. It is wise to avoid large groups of people to avoid unnecessary exposure to illnesses. Make sure all visitors are completely healthy before inviting them to visit the baby. Even a simple cold can result in a fever and possible hospitalization during the first 1–2 months of life. All visitors should wash their hands and/or use hand sanitizer before touching your infant. Infants should avoid air travel until the first set of vaccines is given. Throughout life, the spread of illness can be reduced by thorough and frequent handwashing, the use of hand sanitizer, and not sharing drinks and utensils. Develop the habit of sneezing into your elbow—not your hands—and teach your children the same. Wash your hands immediately after touching your nose or mouth or if you inadvertently cough or sneeze into your hands. If you have not already done so, you, your partner, and all child care providers should receive the Tdap vaccine to help protect your baby from pertussis (whooping cough). We also recommend the influenza vaccine when it is available.

Though many of the items listed below can be completely normal, please call us to discuss further is your baby **shows any of the following signs:**

- Fever greater than 100.4°
- Irritability or a significant behavior change
- Poor or infrequent feedings
- Significant diarrhea or bloody stools
- Persistent vomiting
- Infrequent urination
- Redness, rash, or a foul odor around the umbilical cord
- A persistent diaper rash
- Bleeding or persistent oozing from the umbilical cord stump
- Persistent or recurrent eye discharge and/or redness
- Significant body rash

- Redness and increased swelling of the breasts

JAUNDICE

Jaundice is a yellow discoloration of the skin and the whites of the eyes due to an elevated level of the chemical bilirubin in the blood stream. There are many reasons for jaundice in newborns, and it is more common for a newborn to be jaundiced than not. However, if your baby has significant jaundice, we will take steps to evaluate and treat it as needed.

NAILS

Fingernails and toenails do not begin to calcify until 2 weeks of age and can initially be very soft, like tissue paper attached to the skin. You may safely trim your child's nails from birth. Be careful in cutting the nails, or, safer yet, use a nail file to even the rough edges so your infant does not scratch herself. Do not rip or pull hanging nail ends or cuticles. Cut toenails straight across (not rounded at the edges) to prevent ingrown toenails. You may find it easier to trim your baby's nails while she is sleeping.

PACIFIERS

Sucking is a natural soothing mechanism for babies. A pacifier may be introduced soon after birth or, if you are nursing, when you feel you have adequately established breastfeeding. There is no one best pacifier. Find the one that satisfies your infant. Please note that if your baby does prefer to sleep with a pacifier, it is a potential means of SUDI prevention (see “Sleep Safety”).

POSTPARTUM DEPRESSION

Your baby is our patient, but the health and involvement of the *whole* family is important to us. While we offer some information on postpartum depression (PPD) here, please call us with your concerns.

PPD occurs in 10% of women after delivery, but fathers can also suffer from PPD. Symptoms include mood swings, anxiety, sadness, irritability, crying, decreased concentration, and trouble sleeping. More severe symptoms include an overwhelming sense of fatigue, loss of appetite, insomnia, intense irritability, lack of joy in life, feeling of shame or guilt, difficulty bonding with the baby, withdrawal from family and friends, and thoughts of harming yourself or the baby.

Some people are at a higher risk for PPD, such as those with a family or personal history of depression or anxiety. Having unrealistic expectations of motherhood and breastfeeding, a sense of anxiety about returning to work, a difficult pregnancy or delivery, a demanding baby temperament, a lack of social support, marital stress, or a recent crisis in life may all contribute to PPD.

There are a few steps to take to try to prevent PPD:

- Sleep—maximize any sleep opportunities
- Healthy eating and drinking more than 64 oz of water a day
- Regular exercise—even 30 minutes of walking may help
- Connect to friends and family for support
- Visit a local New Moms Group (Reston YMCA has a free group on the 1st and 3rd Tuesdays. Babies are welcome to come, just show up.)

To seek medical help, call us and we will connect you to providers that can help. You can also visit www.postpartumva.org for great resources, telephone support, a listing of local support groups, and medical provider listings.

PPD is *not* a character flaw or a weakness. Please seek help if ever needed. Untreated depression affects not only you, but the development and welfare of your children.

SPITTING UP

Spitting up is very common in newborns and infants. It is usually normal, especially if your baby is gaining weight and generally happy. If you feel that your baby has forceful vomiting or is especially fussy, please call us.

SKIN AND RASHES

Newborn skin may exhibit a variety of bumps and rashes. These are normal and most will clear spontaneously. There are several benign newborn rashes, some of which are listed below:

- **Milia:** You may notice little white bumps on your baby's face, especially on the forehead, nose, and cheeks. These are milia and are composed of normal skin cells. They will clear on their own without any treatment.
- **Dry, scaly skin:** A newborn's skin may be dry and peeling, especially around the wrists, ankles, and other creases. This usually clears within 3–4 weeks and requires no treatment.
- **Heat rash:** Small red bumps on your baby's skin may be due to heat. It usually improves in a cooler environment and by loosening tight clothing under the neck and arms. Powders and ointments are not necessary.
- **Acne:** Your baby is exposed to your hormones before birth and may exhibit a mild case of acne, usually between 3 and 10 weeks of age. This also clears spontaneously and requires no treatment.
- **Diaper rash:** Factors that tend to encourage diaper rash include continuously wet or soiled diapers or the chemicals in diapers and wipes.

Prevention of diaper rash includes frequent changing, washing the area with water, patting dry, and then air drying well before using a barrier cream, such as petroleum jelly. Consider sensitive-skin diapers and wipes.

- **Birthmarks:** Babies may develop or be born with a variety of "birthmarks," varying from transient to permanent. Common transient birthmarks include pink patches on the face/neck or blue-gray patches on the back, buttocks, or legs. Please discuss with your provider if you have any concerns or questions.
- **Cradle cap:** This is extremely common. Many children develop cradle cap during the first few months of life. It can range from a flaky scalp to yellow, greasy-appearing scales on the scalp. To remove the scale, clean as usual using a mild shampoo, and brush the scalp with a soft-bristled baby brush. Brush in circular motions to loosen the scale. If this is ineffective, you may try an antidandruff shampoo such as Head & Shoulders or Selsun Blue. Please note that these shampoos may be irritating to your baby, and you will need to take caution to protect your baby's eyes. Using a washcloth to apply the shampoo may be helpful. Allow the lather to sit on the scalp or affected areas for a few minutes and then rinse carefully. You can do this a few times a week. It may take several treatments over several days but is usually effective. If the rash is persistent, widespread (in eyebrows, behind neck, in armpits, on chest, and in diaper area), or if it seems to be weepy or infected, please call us for an appointment.

SLEEP SAFETY AND INFANT SLEEP PATTERNS

It is extremely important that you keep your baby in a safe sleep environment to reduce the risk of SUDI. Some recommendations for sleep safety are listed below. Please discuss further at your newborn visits if you have any questions. Some recommendations for sleep safety include:

- Place your child to sleep
  - On her back *(**not** side or stomach)*
  - In a crib/bassinet on a firm, flat surface—no incline or positioners!
  - In her parents' room but not in their bed
  - *Without* any loose blankets or soft items (such as pillows or toys)
  - With a pacifier in her mouth if she takes it (once breastfeeding is adequately established)
- Do not use positioning devices
- Do not over bundle your baby—it is safer for a baby to be slightly cooler than too hot
- Avoid cigarette-smoke exposure
- Do not use crib bumpers
- Breastfeed if possible
- Keep a fan on in the room

Infants usually sleep around 20 hours per day initially. This tapers off as she grows older. Some babies need less sleep than others. Your infant may not distinguish between night and day until she is around 3–4 months of age. By then she should be sleeping more at night and less during the day.

Infants make several different sounds, have variable breathing patterns, and move around a bit while sleeping. Babies, like adults, have sleep cycles and may have soft awakenings as their sleep cycles end.

Helping your infant develop healthy sleep habits from the start is important. Sleep is not only vital to a developing baby but also to the well-being of the parents and the entire family! It may be a good habit to start putting your baby to sleep drowsy but awake, even as early as a newborn. She can then eventually learn how to put herself to sleep and self-soothe during her natural sleep awakenings. “Crying it out” is not recommended in the newborn period. If you would like to discuss your child’s particular sleep habits, please schedule a visit with us.

SNEEZING AND CONGESTION

Sneezing is common in the newborn. Mucus from birth and lint may get caught in your infant’s nose. Sneezing is a natural reflex to clear out this passageway. Your infant uses her nasal passages almost exclusively to breathe until she is about 2–3 months old, and a small amount of normal mucus will cause her to sound very congested. Be assured that your child will not choke on this small amount of mucus. Unless there is significant difficulty in feeding or sleeping, it is not necessary to suction the nose of your infant.

A bulb syringe (ear syringe) may be used to remove mucus. Be aware that overly vigorous suctioning can also irritate the nasal lining and make congestion worse. Saltwater (saline) nose drops (¼–½ teaspoon of salt in 1 cup of boiled or bottled water or over-the-counter saline preparations) may be used to loosen secretions that are deeper and cannot be removed with the syringe. Place a few drops of salt water in one nostril, allow it to sit a few seconds and then suction the nostril or gently compress and "milk" the nose. Repeat with the other nostril.

SPOILING

Many parents are concerned about spoiling their infant. It is important to remember that your baby is totally dependent on you for her physical and emotional comfort. It is through pleasant experiences such as touching, holding, and rocking that your baby experiences security and trust. Generally, your baby cannot be spoiled during the first year of life, and you will be repaid many times over for the love you give during these crucial months.

STOOLS

Just as every adult establishes a bowel pattern, your baby will as well. Newborns may have a stool with every feeding or only one a day. After a few weeks or months, they may go for several days without a stool. This is completely normal.

As long your baby's stools are soft, it is not considered constipation.

A baby's first bowel movements are black and sticky. Within a few days they will turn to a yellow green. Breastfed infants will have watery, explosive stools with a seedy consistency. Bottle-fed infants also have yellow, seedy stools, but the consistency is thicker. Some infants have green stools. Grunting and straining are very common during the first several months and are due to the physical process of having a bowel movement. Please contact us if your baby has blood or other concerning findings in her stool or stool pattern.

VACCINES

We wholeheartedly support immunizing your child to protect against vaccine-preventable illnesses. Our vaccine schedule is based on recommendations by the AAP and Centers for Disease Control and Prevention (CDC).

It is fine to vaccinate children during minor illnesses, such as the common cold. **Remember, the benefits of being protected against these potentially life-threatening diseases and their many complications greatly outweigh any risk from receiving the vaccines themselves.** If you are interested in researching more information on vaccines, please be sure your resources are reliable and based on scientific evidence. For questions about the vaccines your child will receive, visit http://www.cdc.gov/vaccines/ or http://www.vaccine.chop.edu.

You will receive information on each vaccine your child is scheduled to receive during your visit. If you have additional questions, we are happy to address them.

Parents and child care providers should be vaccinated against pertussis (whooping cough) and influenza. Parents should also ensure they are immune to chicken pox, and mothers should be immune to rubella (this is checked during prenatal visits with the obstetrician).

WELL-CHILD APPOINTMENT SCHEDULE

Many parents are curious about the schedule of visits. We see babies in the first few days after birth. The schedule of health maintenance visits then begins with the 2–4-week visit, followed by visits at 2, 4, 6, 9, 12, 15, 18, 24, 30, and 36 months. Yearly visits are then recommended. At each appointment, we will address age-appropriate growth, development, screening, safety, lifestyle, and immunizations. Screening and vaccine guidelines are constantly changing, and we update our practices accordingly. For vaccine schedules, please visit http://www.cdc.gov/vaccines.

PART 2: COMMON CHILDHOOD ISSUES AND ILLNESSES

BEHAVIOR AND DISCIPLINE

Children are very different from one another. In talking with other parents or

comparing your first with your second child, this will be quite evident. Each child has his or her own personality and behavior. It is this limitless combination of traits which makes every child special and unique. Some children will be more demanding of your time, some will be more interested in entertaining themselves. Some will be placid. Some will be very curious and into everything. A full discussion on behavior and discipline is well beyond the scope of this pamphlet, but whatever your child's behavior, there are a few guidelines to follow.

For infants: Remember that your children will always be watching you, listening to you, and learning behaviors from you (even when you think they are playing over in a corner of the room), so be very conscious of setting a good example. Through the first year and a half, facial expression and tone of voice may be sufficient to modify your child's behavior. Removing your child from the problem may be necessary. Do not expect them to comprehend reprimands at this age. Do compliment good behavior and remember to pay quiet attention to your child when she is entertaining herself. This will encourage more quiet self-play. By age 1½ years, your child will probably comprehend almost every simple thing you tell her; and, although it may vary from one child to the next, it is around this time that more specific types of discipline may be employed.

For early toddlers: At the early toddler age, discipline is concerned simply with safety. Structure your child's environment so that minimal safety risk will be encountered. Allow her explorations to stimulate her curiosity and intellect. Pick a few rooms where you do most of your family living and childproof those well. If she gets into or onto something dangerous say no firmly but gently, then physically remove her from the situation and distract her with something else without drawing too much attention to the offending behavior. Choose your battles and ignore irrelevant or unimportant behavior that is unrelated to safety at this young age, no matter how annoying (for example, thumb sucking, nose picking, whining). Constant criticism only teaches your child to tune you out. State your rules firmly but gently with few words so the message does not get lost ("we don't hit the dog") and follow up with explicitly stated expectations so your child is left with a positive thought to focus on instead ("we pet the dog"). The message registers better if you get close to your child, gently touch her, make eye contact, and speak in a firm but not harsh voice. Nonverbal disapproval—raised eyebrows, hands on hips, or a simple interruption of your activity with significant eye contact can be very effective in stopping behavior. Consistently applying the rules among all caretakers is important.

Attention-getting behaviors (most commonly temper tantrums) are best ignored, although doing so will often be difficult. Surprisingly, an 18-month-old would rather get negative attention (punishment) for her behavior than no attention at all. Positive reinforcement of good behavior is probably the most important way in which we structure behavior. Parents should strive to say at least one positive thing to their child for every negative thing said; some behavioral specialists suggest that giving 3–4 praises for each reprimand is best for establishing self-esteem and motivating good behavior.

Time-outs: Somewhere between ages 1 and 2 years your child will probably be ready to start time-outs. Placing your child in a time-out ("cooling off") place, such as a special chair or room designated as a spot to sit for a few seconds to minutes, can be a very effective way to truncate undesirable behavior. When your child understands the concept of logical consequences (for example, “If I pee in the potty, I will get a sticker and a hug”), she is ready for time-outs. Begin by picking the time-out place, a dull but not frightening or dangerous place (such as a chair facing a window or wall, the stairs). Briefly explain what a time-out is and identify the types of behaviors that will be punished by time-outs at first. Start with behaviors injurious to others (biting, hitting, kicking), and when the time-out technique has been well established add behaviors to the list, such as intentionally harming physical property or open defiance of an important request. When your child misbehaves, she gets no more than one warning to stop the behavior before being escorted to or asked to sit in the time-out place. With children who have a hard time quickly changing the course of their behavior, counting to 3 out loud will often give them the necessary time to reorient their priorities to line up with yours. If compliance has not started in earnest by the time you reach “3,” escort your little one to the time-out location. The time-out should continue until your youngster is back in control of herself and for no longer than 1 minute for each year of life (so, 3 minutes for a 3-year-old). Brief time-outs are frequently the most effective because they are deemed less punitive by children and are better tolerated by parents too.

When time-outs are brief, parents are more likely to use them consistently. This is important because time-outs are most effective when they are consistent, immediate, and predictable. Ideally, a time-out should be imposed immediately after an infraction and every time the infraction is observed. Kitchen timers are highly recommended for keeping track of the time-out; a child will not take a timer’s authority personally.

Speak as little as possible while imposing time-outs. Briefly and clearly identify the infraction for your child on the way to time-out and say nothing more (“Oops, time-out for hitting”). Do not speak to or pay attention to a child in time-out. If your child escapes, gently escort her back in and restart the timer. When the timer goes off, simply tell your child that time-out is over and she may come out. Do not lecture, demand an apology, or discuss the infraction any further. This only serves to revive resentment and reduce a child’s motivation to be compliant. Your child knows what she did wrong. Move on. Find something to praise her for as soon as is plausible to get things back on the right track. Time-outs are a very effective means of discipline that can be used up until about 10 years of age for most children. However, using logic and natural consequences are also effective. We are happy to have a visit to discuss which methods may be best for your family.

For older children: For the older child, additional means of discipline may be added as your child develops the ability to understand them. Logical consequences, such as taking away a toy, object, or privilege if it isn’t cared for appropriately is often effective (“If you throw your toys I will have to put them away”). Delaying a privilege until a responsibility is completed can be helpful

("you may have your tablet after you set the table and feed the dog"). Have family conferences about particularly thorny issues and adopt joint problem-solving to show you respect your children's opinions and independence.

Applying consequences immediately after misbehavior is most effective. Discipline should be brief and should be imposed by the adult who witnessed the infraction. Using "I" messages ("I am upset that this room is a mess") will minimize defensiveness and improve your chances of being understood. It also serves to model awareness of one's feelings to your children. Yell as seldom as humanly possible. We all do it, but it is a sign that discipline is breaking down, and it usually means that you are doing too much talking and not imposing other strategies quickly enough.

Corporal punishment: We do not approve of spanking or other forms of corporal punishment. Corporal punishment increases aggression and is not instructive. Correct with love, speaking to your children the way that you would wish to be spoken to. Children learn to be respectful when we model respectful behavior towards them. Remember that the word *discipline* comes from the word *disciple*, which means "to teach." The more your child sees and models herself after your good behavior, the less discipline will be necessary. Praise desired behaviors not only verbally, but also by using nonverbal cues, such as moving close to your child, smiling, making eye contact, and being affectionate.

This just scratches the surface of discipline—please see the bibliography for more resources.

CAR SEATS

Keeping your child safe while riding in the car is one of the most important responsibilities you will have as a parent. Despite the improvements that have been made in car safety and technology, car crashes continue to be one of the leading causes of death for children in the United States. The current car seat and booster seat recommendations are based on the most recent studies, which have compiled data on the injuries and fatalities that have occurred in children involved in vehicle accidents in the United States.

Infants should always ride in a rear-facing car seat. It is recommended that infants and toddlers remain in rear-facing car seats until at least 2 years of age or until they reach the maximum weight and height capacity for the rear-facing car seat.

Once a toddler has reached 2 years of age or has outgrown the rear-facing car seat, she can be transitioned to a front-facing car seat *or* you may continue to keep your child in a rear-facing seat until the car seat requirements mandate.

It is safest for children to remain in a car seat with a 5-point harness until they have outgrown the car seat in weight or height.

Once your child has outgrown the forward-facing, 5-point harness car seat, she

should be moved into a booster seat until she has reached a height of 4 feet 9 inches and is between 8 and 12 years old. She should remain in a booster seat until the shoulder belt lies across the middle of her chest and shoulder, not against her neck, and the lap belt fits low along her hips and upper thighs, not against her stomach.

Riding in the back seat is mandatory until the age 13 if you have a passenger-side airbag in your vehicle. The best way to convince your child to cooperate with safety restraints is by setting a good example and always wearing your seat belt.

Cars manufactured after 2002 are equipped with the LATCH system that allows for easier installation of car seats. Please refer to both the car's manual and the car seat's manual before installing any car or booster seat. Local police and fire departments may have personnel certified in car seat installation. Check the website of the National Highway and Traffic Safety Administration (www.nhtsa.gov) or call your local police or fire department to have your installation checked.

CHICKEN POX

Chicken pox is a common childhood illness but is vaccine preventable. A 2-dose regimen of the vaccine may be as high as 98% effective in preventing disease and 100% effective in preventing serious disease. As such, we do not see the typical rash of chicken pox very often anymore. However, some kids may have an atypical, mild form of chicken pox even if they have been vaccinated.

Children with chicken pox, even atypical chicken pox, should be kept away from anyone who has not had the disease or has not been vaccinated until their last scab is well formed. It is particularly important that immune-compromised individuals, like transplant patients or newborns, not be exposed to chicken pox as they are more likely to have a severe case. Chicken pox can be very dangerous in adults. Any adult who has not had chicken pox should contact his/her health care provider for vaccination.

If you feel that your child has chicken pox, please call our nurse line to talk through management. If you feel compelled to confirm the diagnosis, it is very important that you tell the nurse that you suspect chicken pox. To protect our newborns and other susceptible patients, please do not bring your child into the office. When you arrive, please leave your child in the hallway and pop in or call to let us know you have arrived. A nurse will escort you in our back door to minimize exposure to the rest of the patients.

COMMON COLD

Symptoms of a cold vary and may include clear, yellow, or green mucus from the nose, as well as sneezing, cough, congestion, muscle aches, fever, and mild headache. Colds are caused by several different viruses that do not respond to

antibiotics or other medication. Generally, our body's defenses will fight off the most uncomfortable symptoms in 4–7 days, but the cough and runny nose may persist for 2–3 weeks. (Please see the graph of symptom duration on page 45.) Sometimes we can help our children feel better by performing a few simple tasks for nasal congestion (stuffiness):

Salt water (saline) nose sprays or drops: Add ¼ teaspoon of salt to 1 cup of warm water (water should be bottled or boiled and cooled for intranasal use) or purchase an over-the-counter preparation. Place a few drops into each nostril and then suction the loosened mucus with a bulb syringe (tapered tip). This is usually helpful for children under 2 years old. For an older child, instill 4–5 drops into each nostril, and have her lay down with her head tilted back for a minute or two. She can then sit up and blow her nose.

Use a cool mist humidifier while your child is sleeping when your heat is on. Your humidifier must be cleaned and dried thoroughly each day to avoid a buildup of molds. Bear in mind that humidifier use, despite cleaning, may increase the presence of molds and dust mites in your home, and this may worsen allergy symptoms. Do not use a hot humidifier.

Try steaming the bathroom by turning on the hot shower with the door closed if your child has thick mucus or a dry cough. Generally, 15–20 minutes will provide enough relief to help your child sleep.

Increase fluid intake, and do not be alarmed if your child's appetite decreases for a few days.

Honey, especially buckwheat honey, may reduce your child's cough. One teaspoon of honey may be offered to soothe the throat and decrease coughing if your child is older than 1 year of age. Honey given to those under 1 year old may cause botulism.

Medications: We do not recommend over-the-counter cough-and-cold preparations for infants and young children. In studies, they are generally ineffective and some of them can cause serious side effects.

Call us for an appointment if your child has difficulty breathing, persistent high fevers over 101 degrees for more than 3 days, or if you have any concerns.

CONSTIPATION

In the older child, constipation is the painful passage of firm bowel movements, the inability to pass stools despite feeling the urge to defecate, having infrequent bowel movements, or going 5 or more days without a bowel movement. It is usually related to the child's diet but can be caused by withholding stool. If constipation begins during toilet training, there may be too much psychological pressure being placed on the child.

Large or hard stools without pain can be normal. Babies less than 6 months of

age commonly grunt, push, strain, draw up the legs, and become flushed in the face during the passage of bowel movements. These behaviors remind us that it is difficult to have a bowel movement while lying down. Also, babies do not coordinate the pushing with the release of the voluntary external sphincter.

Changes in the diet usually relieve constipation. After your child is better, keep her on the nonconstipating diet so that it does not happen again.

Treatment in infants less than 4 months old: If the stool is somewhat soft, there is no need to do anything because the frequency of stools is highly variable in this age group. If stools are hard like marbles, increasing the fluid intake by increasing the frequency of feedings or adding an ounce of water to the diet each day usually helps.

4 months to 1 year old: If your baby is eating solids, add fiber rich foods twice a day. These include apricots, prunes, peaches, pears, plums, sweet potatoes, peas, legumes, whole grains, or greens. Avoid strained carrots, squash, bananas, and applesauce. You can also try 2 ounces of 100% pear or prune juice daily.

Toddlers and older children: Feed your child fruits or vegetables at least five times a day (raw, unpeeled fruits and vegetables are best). Some examples are prunes, figs, dates, raisins (if your child is older than 3 years as these may be choking hazards), peaches, pears, apricots, beans, peas, cauliflower, broccoli, and cabbage. You can also try to increase bran, oatmeal, or whole grain products. Plain popcorn is also a high fiber food for children older than 3 years of age. Be sure to avoid any foods that your child cannot chew easily and may pose a choking hazard. Make sure to decrease constipating foods, such as milk, ice cream, cheese, white rice, processed grains (pastas, mac and cheese), applesauce, bananas, cooked carrots, and foods high in sugar.

Ideas for snacks for older kids: Trail mix with nuts, dried fruits, whole grain cereal, popcorn, fruits, vegetables, and nut butters.

Encourage your child to develop a regular bowel pattern by sitting on the toilet for 10 minutes after meals, especially after breakfast. Some children and adults repeatedly get blocked up if they do not do this. If your child is resisting toilet training by holding back, stop the training for a while and put her back into pull-ups or diapers.

Do not give any enemas, laxatives, or suppositories without discussing with your provider or our advice nurses. Call us during office hours or make an appointment to further discuss if your child does not have a bowel movement for several days despite dietary changes, if there are any nonhealing tears in the anal area, if your child is leaking stool onto underwear, or if this is a recurring/persistent problem.

CROUP

Croup is a common viral infection in small children. The characteristic barking, seal-like cough results from inflammation of the trachea (windpipe) just below the vocal cords. Croup usually worsens at night, lasting 3 nights before resolving on its own. Cough medications and antibiotics are not necessary or effective. To manage croup at home, it may be helpful to run a cool-mist humidifier in your child's room. Remember to wash out the humidifier daily. If the croup continues to progress, take the child into the bathroom, close the door, and steam the bathroom up by running hot water through the showerhead. Offering your child warm liquids to drink may also help stop the coughing spasm. You may also try putting your child's face up to an open window or taking her out into the cool night air. We can see your child the next morning to discuss prescription treatment options if necessary.

You should take your child in to see a doctor/emergency department ***immediately*** if:

- Your child is struggling for air or can't speak for lack of breath
- She is drooling or refuses to swallow
- You have concerns about the way your child is breathing or the noises she is making while breathing
- You observe any blue discoloration of the mouth or fingertips

DIARRHEA AND VOMITING

Generally, medication is not necessary to relieve the abdominal pain or decrease the number of bowel movements during episodes of diarrhea and/or vomiting.

Good fluid intake is the most important part of treatment. The following instructions may be helpful.

When vomiting is present, give the stomach some time to rest. Then slowly introduce a rehydration solution such as Pedialyte or an equivalent electrolyte solution in very small amounts given frequently as described below. These electrolyte solutions are specifically formulated to maintain the normal balance of water, electrolytes (salts), and sugar in a child with a stomach illness. Therefore, it is important that you do not add sugar to the solutions. If your child does not take oral rehydration solutions such as Pedialyte, you may try diluted (½ to ⅓ strength) Gatorade or a similar electrolyte drink. If you are nursing, you may continue to breastfeed, perhaps offering smaller volumes. Formula-fed babies can continue formula in smaller amounts, as tolerated. If your baby vomits with breast milk or formula, try an oral rehydration solution as described below.

For infants, you can give 1–2 teaspoons every 5 minutes or so as tolerated. For older kids, try 2–3 teaspoons every 5 minutes. When this regimen has been tolerated for a few hours without vomiting, you may begin to slowly increase the volume you offer your child. For example, you may try a tablespoon every 5–10 minutes, then an ounce every 10–15 minutes, then 2 oz every 15–20 minutes, slowly increasing the volume in this fashion until your child is taking a normal

amount of fluid. If vomiting recurs during this time, start the process over. After several hours without vomiting, other clear liquids and foods may be reintroduced.

In the child has diarrhea without vomiting, the treatment goal is to prevent dehydration by increasing fluid intake. If diarrhea is frequent or large in volume, you may need to use commercially prepared rehydration solutions such as Pedialyte to help prevent dehydration. Food restriction is not indicated as a treatment for diarrhea. In fact, prolonged dietary restriction may slow the body's healing process. Probiotics may be helpful in treating your child's diarrhea. They are generally safe when used by otherwise healthy children. Probiotics are found in yogurts and over-the-counter preparations, like capsules, liquids, and wafers.

Please call us or bring your child in if any of the following occur:

- Vomiting is severe or persists for longer than 8 hours in infants less than 1 year of age or 18–24 hours in older children despite the appropriate use of a rehydration solution
- Signs or symptoms of dehydration develop (dry mouth, sunken soft spot, absent tears, or urination less than every 4 hours)
- Recovery is not progressing as you expect
- Significant abdominal pain or back pain is present
- Extreme drowsiness or irritability is noted
- Blood or mucus is found in the stool
- Your child has pain on urination
- Blood or bile (a green-colored substance) appears in the vomit
- Your child won't drink
- Your child's abdomen is markedly distended
- Diarrhea persists for longer than 1–2 weeks

FEVER

Note: For medication doses, please see the dosing tables at the end of the booklet.

Fever is a frequent cause of parental concern. In fact, many parents unnecessarily give their children medication to treat fever, even when the temperature is near normal. However, it is important to remember that fever is not a disease itself. Fever helps our bodies fight infection. The height of your child's fever does not predict how serious an illness is, nor does a high temperature cause harm to a generally healthy child. Response to fever medication does not predict severe illness either. It is best to focus on how your child is behaving.

Measuring your child's temperature: a fever is a temperature of 100.4 degrees or more. Temperature will vary depending on where on the body the temperature is taken, the age of the child, and the time of day. We recommend

inexpensive digital electronic thermometers. In most cases, an axillary (underarm) temperature will suffice, even in babies. For older kids (over 4 years), oral temperatures under the tongue are most accurate. Place the thermometer tip in the fleshy pocket beneath the tongue and have the child close her lips firmly around the thermometer. Temporal artery thermometers are newer and not as reliable, though technology is quickly evolving. Ear thermometers are not always reliable.

Fever Therapy

- ***Fevers do not need to be treated with medication unless your child is uncomfortable.***
- Managing the fever by giving your child a lukewarm (not cold) bath and encouraging extra fluids is often all the treatment that is necessary to make her more comfortable from the fever.
- Never sponge or bathe your child with alcohol or cold water.
- Acetaminophen (over age 2 months) or ibuprofen (over age 6 months) may be given for comfort measures. Doses are based on weight. Read the label on your bottle to ensure correct dosing. Also, see our dosing table at the end of the booklet.
- We do not recommend alternating these medications because this can cause confusion and/or overdosing.
- Even with fever management, fever will continue until your child's illness resolves.
- Keep your home at a normal temperature.
- Do not give your child aspirin unless specifically instructed to do so.

While with fever, your child's illness is likely to be at its peak of contagiousness. Please be responsible and keep children at home until they are fever free for 24 hours.

HEAD INJURIES | CONCUSSION

Head injuries are very common in childhood, and it is unlikely that significant skull or brain injury would result from any head injury that did not cause a loss of consciousness. However, if you believe your child has had a significant head injury, please call our office. If your child had a loss of consciousness, persistent vomiting, noticeable change in behavior, or a seizure after a head injury, you should go to the emergency department immediately.

HEALTHY LIFESTYLES

It is important to model a healthy lifestyle for your children. We encourage family meals where adults and kids are eating the same meal at the same time. Half of your child's plate should consist of fruits and vegetables. A quarter should be grains, preferably whole grains, and about a quarter should consist of proteins, such as fish, lean meats, beans, legumes, and nuts. Low-fat or nonfat dairy products should also be included regularly with meals or snacks.

We recommend daily activity and exercise. An active family life is the best way to build a lifelong habit of physical activity. All children should be encouraged to participate in a variety of activities that promote development, such as outdoor play, reading, singing, arts and crafts, and unstructured play. Total screen time should be limited to 1–2 hours a day for children ages 2 years and up. We encourage avoiding screen time for those under age 2 years.

INFLUENZA

We recommend and offer seasonal flu vaccines starting early fall of every year. Flu vaccine recommendations change from year to year, and we update our practices accordingly.

LYME DISEASE

Lyme is a tick-borne illness caused by the Borrelia burgdorferi bacteria. It is transmitted to humans from infected deer ticks that have bitten and remained attached for a minimum of 36 hours. Lyme disease is not transmitted from other animals or people. Signs of early Lyme disease include a bull's-eye rash, fever, fatigue, flu-like symptoms, headache, stiff neck, and joint pain, occurring within 3 to 30 days of a tick bite. These symptoms may last up to several weeks and will go away with or without treatment. If the early infection is not treated, other problems may develop, such as nervous system disorders, heart problems, or joint swelling and pain.

Lyme can be best prevented by avoiding tick-infested areas or wearing long-sleeved shirts and long pants that can tuck into socks. Use insect repellent. Do a thorough tick check after returning from a potentially tick-infested area. If you remove ticks early, you can prevent an infection from taking place.

Please contact us for an appointment if you believe your child has an unusual rash or other signs or symptoms of Lyme disease.

SAFETY

Accidents are responsible for the deaths of more children than are all diseases combined. Most accidents in childhood can be anticipated and prevented.

Car Safety

- Your child should never be left alone around cars because of the risk of being run over when the car is set into motion.
- Your child should never be left alone in a car because of the risk of strangulation from the power windows and overheating.
- Be a good role model and do not talk on the phone or text while driving.
- See the "Car Seats" section for proper method of restraining your child.
- Make sure your teen driver

- Wears a seat belt
- Does not talk on the cell phone or text while driving
- Does not eat or drink in the car while driving

Infant Safety

- Babies may roll over (even in the first weeks of life) long before they are capable of consciously doing so. Make sure your baby is never left unattended, even for an instant, on a raised surface.
- Never place the infant carrier with your baby in it on a counter, table, or chair. She may topple the seat over, resulting in serious injury.
- Make sure you don't drink hot liquids or cook while you are holding your baby as this may lead to serious burns. The safest place for your baby while you cook is in her highchair or play yard.
- Do not use walkers. These can cause injury.

Bathing Safety

Children under the age of 6 years should never be left unattended in the bathtub. Children can drown in an inch of water. Plan ahead and have everything ready before you place your child in the bathtub. When the bath is finished pick up your infant securely under the arms with a towel to prevent slipping.

Water Safety

- Never leave your child alone in or near the water, even for a moment.
- Keep infants and toddlers within "touch supervision" around water.
- Do not use "floaties" as these are not effective safety devices.
- Children ages 1–4 are at a lower risk of drowning if they have had formal swim lessons, but this does not mean they do not need constant adult supervision. Formal swim lessons may be a consideration for your child.
- Adults should not consume alcohol and should eliminate distractions such as cell phone use while supervising children in water.
- Your child should always wear a properly fitting life jacket when on a boat.
- Children and teens should never swim alone. Even experienced swimmers need a buddy!
- If you have a pool, it is recommended to place a fence around it to prevent drowning.
- Please see the section on "Sun Safety" for a review of UV protection.

Household Safety

As your child becomes more mobile, you must protect her from the environment she will be investigating.

- Cover electrical sockets.
- Wall-mounted gates should be installed on all stairways (both at the top and the bottom) until your child can safely walk up and down the stairs holding the handrail. This is usually around the age of 3–4 years.
- Safety latches should be added to cabinets with cleaning supplies, dangerous utensils or equipment, or medicines.
- Look through your child's environment for things that she can pull down on herself—such as floor lamps, top-heavy plant stands, and lamp and appliance cords—and remove them before she starts climbing.
- Check your furniture to make sure it is stable and will not be pulled over by a climbing child. If so, remove it or bolt it to the wall (especially bookcases).
- Tie all curtain and shade cords up out of reach in small enough loops that a child's head won't fit through them. Small children are at risk for strangulation from window treatment cords.
- Toys should have smooth edges and be large enough that your toddler cannot fit them into her mouth.
- Windows should open from the top if possible. If they must open from the bottom, install guards that ensure that only an adult can open them.
- Do not place any furniture in front of a window that would allow a child to climb onto the window, increasing the chance of a serious fall.

Poisons Safety

All toxic materials should be placed out of the reach of your child.

- Certain household plants may be harmful.
- Place all houseplants out of reach and watch your child well when she is playing outdoors as many ornamental plants can be dangerous.
- Call Poison Control (800-222-1222) if you feel that your child has ingested something. Consider programming this number in your phone.
- Never give Syrup of Ipecac.

Bicycle Safety

Make sure that your child wears an approved bike helmet whenever riding a tricycle, bicycle, scooter, skateboard, or skates, or when riding in a bike trailer. This will establish good habits early on.

The most important factor in establishing the bike helmet habit in kids is for all adults to wear a helmet as well!

Guns and Weapons

Guns and weapons should never be in the home.

- If you must have a gun or weapon in the home, make sure it is locked away and that the ammunition is stored and locked separately.
- When your child plays at someone else's home, ask if they have guns and, if so, how they are stored.

Internet Safety

The use of computers is necessary for schoolwork. It can also provide valuable information and entertainment.

- Make sure that you supervise your child's access to the internet.
- Place the computer in a general location so that you are aware of when and what your child is doing. Kids do not need computers in their rooms.
- Set a time limit per day for non-school-related computer use.
- Specify which sites are allowed.
- Install a web-filtering program.
- Discuss cyber-bullying and harassment with your child.
- Discuss social media sites capturing personal information.
- Kids under 13 years old should not be on social networking sites such as Facebook.
- If your teen is on a social networking site, learn about the site and consider joining yourself.
- Discuss posting personal and inappropriate information, and the potential of harming her reputation.
- Remind your teen that what is posted online is permanent.
- Discuss "sexting" with your tween and teen.

Bullying is when a child is picked on by another child over and over. Girls and boys both can be bullies. Bullying can start at a young age.

- There are three types of bullying
  - Physical—hitting, kicking, pushing
  - Verbal—taunting, teasing, hate speech
  - Social—exclusion, rumors
- Bullying happens when adults are not watching. It can happen in person or via email, texting, instant messaging, or social networking.
- A bully has power over the other child.
- Bullying occurs while other children watch.
- Talk with your child about bullying. Discuss how to stay safe and how to respond to bullies.
- If your child is a victim of bullying or is a bully, please schedule an appointment to discuss further. Also, make sure to discuss this with appropriate adults like your child's teacher or principal.

Cyber-Bullying: As more social interaction has become digital, so has bullying.

- Take all threats towards your child seriously.
- Instruct your child on what to do if they are threatened or harassed via text, email, instant message, or social network. Have her not respond to the threat and inform you and/or another trusted adult.
- Save the threat—Write down any identifying information, such as a screen name, email address, or cell number.
- Report the incident to your internet service provider.
- Report the incident to the cyber tip line of the National Center for Missing and Exploited Children (NCMEC), which forwards all reports to the appropriate law enforcement agencies. The NCMEC works with the Federal Bureau of Investigation's (FBI's) child exploitation task force, which investigates cyber-bullying and child exploitation cases.

SCREENING

At each health maintenance visit, we screen for various age-appropriate health risks as recommended by the AAP and CDC. Some examples are listed below:

Postpartum depression: Mothers and fathers of new infants are screened during well visits between ages 2 weeks and 6 months.

Tuberculosis: We regularly screen for tuberculosis. If risk factors are present, such as exposure to known contacts or recent travel to a high-risk country, we may require further testing.

Lead: We have found that we live in a very low lead-exposure area. We screen for lead exposure by obtaining a medical history. Based on the screen, we will pursue further testing as needed.

Lipid screen: Cholesterol is checked at age 9 years. We may check cholesterol earlier is there are significant risk factors, such as a parent with high cholesterol.

Anemia: We screen for anemia by doing a simple blood test. We usually screen for anemia at age 9–12 months or if we determine your child is at risk for anemia.

Vision/Hearing: Your child will have a newborn hearing screen prior to leaving the hospital. In the office, vision screening begins at age 12 months and hearing at age 4 years.

Teen screens: Beginning in the adolescent years, your teen or tween will be asked to answer a confidential health questionnaire. This is a means for teens to discuss with their providers certain topics that they may not feel comfortable addressing in front of their parents. You will also be asked to complete a corresponding parent questionnaire.

SLEEPING

Encouraging healthy sleep habits is important for your child at every stage and age. As more sleep research is conducted, we are realizing the detriment that sleep deprivation can have on children (and adults) of all ages. When children are chronically sleep deprived, they may develop learning, behavioral, and mental health problems. Lack of sleep is also associated with obesity.

Some tips for ensuring your child gets adequate sleep:

- Set a regular sleep time and wake time.
- Establish a bedtime routine.
- No TV, computer, phone, or other media devices in the bedroom.
- No caffeine.
- Keep the bedroom dark, quiet, and slightly cool.
- Encourage exposure to natural daylight soon after rising in the morning to "set" the biological clock.

General Sleep Averages (these vary from child to child):

0–4 weeks	16–18 hours total, 4 naps, night feeds every 1½–3 hours
1–2 months	15½–17 hours total, 3–4 daytime naps, 2–3 night feeds
3 months	15 hours total, 4- to 8-hour nighttime stretch, 2–4 naps
4–5 months	10–11 hours at night, possibly an 8+ hour stretch, 3 naps
6–8 months	10–12 hour at night, 2–3 naps
9–12 months	11 hours at night, 2 daytime naps totaling 3 hours
12–18 months	13–14 hours total, 11 hours at night, 2 daytime naps
18 months–2 years	12–14 hours total, generally 1 nap a day
3–5 years	11–12 hours a night
5–12 years	10 hours a night
13–17 years	9 hours a night

Sleep Terrors: Sleep terrors are reported in 1–6% of the pediatric population. They are generally seen after 18 months of age and usually disappear by the teen years. Sleep terrors are characterized by thrashing about and calling out, crying, and even yelling. Attempts to calm your child may not help, but eventually she will settle back down. Although your child appears awake, she will have no recollection of the event in the morning. Sleep terrors may be triggered by sleep deprivation, stress, or certain medications. They may improve or even disappear if the underlying sleep deprivation is resolved.

Nightmares: Nightmares are common in preschool and school-aged children. In contrast to sleep terrors, children tend to become fully awake after a nightmare. They can remember details and frequently talk about their nightmare the next morning. Occasional nightmares are not worrisome, but recurrent nightmares or those with disturbing content may indicate excessive daytime stress. Some children are very sensitive to dramatic media content. Even children's movies and cartoons can be disturbing to some children.

Please schedule an appointment for a consult if you have concerns about your

child's sleep.

STREP THROAT

Most sore throats are caused by viruses but are often indistinguishable from strep throat. Strep can be adequately treated with antibiotics to help prevent rare complications such as rheumatic fever. If your child has a severe sore throat, especially if it is accompanied by fever, headache, or stomachache, a throat culture should be performed in our lab. If the fever is high or there is extreme pain, difficulty in opening the mouth, inability to swallow, difficulty breathing, or drooling, your child should be seen before a strep test is performed. Though we typically treat strep in children over age 3 years, strep throat is not an urgent disease. Your child can be evaluated during the next available office appointment if she shows signs of strep throat.

SUN SAFETY

The basics:

- Cover up—clothing, hats with broad rims, sunglasses—even for babies!
- Stay in the shade.
- Limit sun exposure during peak sun hours: 10am–4pm.
- Preapply sunscreen 30 minutes prior to exposure.
- Reapply at least every 2 hours and after swimming, exercising, or toweling off.

Shade, clothing, broad-brimmed hats, and sunglasses are the best sun protection measures for everyone. For those over 6 months of age, sunscreen should be applied to all areas of skin not covered. In infants under 6 months of age, the AAP recommends using sunscreen on small, exposed areas of skin if the above measures will not be adequate to protect from sunburn. Use a sunscreen with an SPF of 30 or more with broad-spectrum coverage. Both chemical-based sunscreens and barrier (or physical) sunscreens are available. Both types are effective. However, the zinc oxide or titanium dioxide barrier screens may be more suitable for sensitive skin.

Clothing can be a simple and practical means of sun protection. Infants and children may be dressed in cool, comfortable clothing and wear hats with brims. Not all clothing is created equal. Clothes that cover more of the body provide more protection. Synthetic materials are more protective than cotton, and a darker and tighter weave lets in less sunlight than a looser weave. Some clothes have been treated with chemical absorbers or optical brighteners to increase the ultraviolet protection factor (UPF). The UPF measures a fabric's ability to block UV rays from passing through the fabric and reaching the skin. The UPF is classified from 15 to 50. Higher UPF provides greater protection. UPF clothes are commonly referred to as "rash guards."

The treatment of sunburn is generally symptomatic, such as cool compresses and ibuprofen, so prevention is key. If you feel your child's sunburn is severe, call

us.

TOILET TRAINING

The timing of toilet training varies across cultures and families. The AAP recommends that children not be toilet trained until they exhibit signs of readiness, such as the ability to sense the urge to go to the bathroom and communicate the need for assistance to make it to the toilet. If your child shows an interest in mimicking other adult bathroom routines, such as brushing teeth and washing hands, she may be ready.

Readiness occurs at different ages in different children. Your child is an individual and does not need to fit into other people's schedules. There is no need to be pushy or punitive. Children may become ready to toilet train around 18 months of age, since their digestive system and bladder have matured and they are able to delay bowel movements or urination to get to the potty. However, studies show that it is unlikely that a child will be toilet trained before 27 months. Some children will not be trained until age 3 years or later.

You may begin by buying your child a potty seat. Training at this time may include discussion of the association between the child's potty chair and toilet use. Social readiness is essential, as your child may have the desire to imitate this behavior and please you. It may even be a simple desire to wear "big kid underwear." Some experts recommend making diaper changes more routine rather than associated with play and fun.

At first, you may take your child in to sit on the potty in all her clothes. Perhaps sit and read to her or give a snack at this time. Never pressure her to stay on the chair. When she seems willing to participate you may try to help her recognize the signs of needing to use the potty and have her sit on the chair without her diaper. You may empty diaper contents into the toilet. Avoid flushing, initially, as this may frighten toddlers.

Continue practicing, especially once your child exhibits a desire to comply or please you. Offer praise and positive reinforcement for urine or stool in the toilet. As interest grows, diapers and pants can be removed for short periods, often referred to as a "bare-bottom weekend." Eventually, you can transition to training pants. Nap and night training are left until after daytime dryness is achieved.

Children learn better with positive reinforcement for success rather than punishment for failure. Positive reinforcement may consist of verbal praise, a hug, or a tangible reward.

There are multiple approaches to toilet training. Many books have been written on the subject. Please discuss with us during your child's visits if you would like more information on the topic.

A few things to keep in mind:

- Children may learn quickly that being on the potty gets a lot of positive attention!
- Have potty chairs in easily accessible locations.
- Teach boys to urinate while sitting. They can later learn to stand.
- Be consistent.
- Make sure your child's stools remain soft. Discuss with us if you feel your child is withholding stools.
- If you feel like your child is resisting or not progressing, take a break and try again in a few weeks or months.
- It is never ideal to potty train when there are stressors at home or major changes, like a new house or a new baby.

TRAVEL

It is a good idea to schedule a travel consult with us prior to any international travel. To best protect your family, we recommend scheduling your visit at least 2 months in advance of anticipated travel. That way, if your child needs any special immunizations or medications, we will have adequate time to immunize her.

It is helpful if you bring a copy of the CDC travel information for the specific country and region where you are traveling. It is also very important to let us know when you schedule your appointment where exactly you are traveling. This will help us best provide information and appropriate care for your child.

VITAMINS AND IRON

Vitamins: Most children will receive adequate nutrition from their daily diets. However, we do recommend vitamin D supplementation for all infants and children as follows:

- Breastfed and partially breastfed infants should be supplemented with 400 IU a day of vitamin D beginning in the first few days of life. Formula-fed babies consuming less than 1 liter (about 32 ounces) of formula should also receive vitamin D. We recommend 200–400 IU per day.
- Children and adolescents over age 1 year should receive at least 600 IU of vitamin D daily. Some vitamin D may be consumed via fortified foods, such as milk. A supplement is usually required to meet the 600 IU/day recommendation.

Vitamin D is available over the counter in various infant drops and children's chewable vitamins.

Iron: Your baby received her iron stores during the third trimester of gestation. However, at around age 4–6 months, those stores begin to run out and your baby requires iron from food sources or a supplement. You can start an iron supplement at age 4 months, or your baby can get the necessary iron from iron-rich foods, such as meats, leafy greens, or legumes. We will check

your baby for anemia at age 9–12 months.

VULVOVAGINITIS

Occasional inflammation of the vulva is common in many toilet-trained girls and often is a result of inadequate hygiene or irritation from soap. Classically, girls will complain of itching and burning or pain with urination. Discomfort is relieved by pouring warm water over the vaginal area while she urinates on the toilet.

To manage this at home, have your daughter sit in the bathtub and swish water multiple times towards the area of irritation. You may add a few spoons of baking soda in the water to help soothe the skin. Cleanse the area gently to remove all debris.

For temporary symptom relief, you may use a topical, over-the-counter steroid ointment, such as 1% hydrocortisone, or a diaper cream.

Prevention is nine-tenths of the battle. If your child is prone to vaginal irritation, avoid bubble baths, tights, and leggings, and change out of wet bathing suits quickly. Wear loose, cotton underwear. Ensure that your child is wiping front to back and that all soap or debris is washed from her genital area. Nightly showering or bathing is an important part of prevention. On evenings that there is no time to bathe, cleanse the vaginal area by rinsing your daughter's genitalia with 4–8 ounces of warm water with a squirt bottle while she sits on the toilet. Please call us or bring your child in if you think her symptoms are persisting or not improving within 24 to 48 hours, or if she complains of back pain or abdominal pain, has fever or vomiting, has discharge, or has evidence of trauma.

ADDITIONAL RESOURCES

ACETAMINOPHEN DOSING

Age: over 2 months
These doses are given every 4–6 hours.
Do not exceed 4–5 doses in a 24-hour period.
Do not exceed recommended doses! Though commonly available dosing is 160mg/5ml, other formulations are still on the market.

Make sure you follow the dosage schedule that is appropriate to the concentration of acetaminophen you are using (5 mL = 1 teaspoon)!

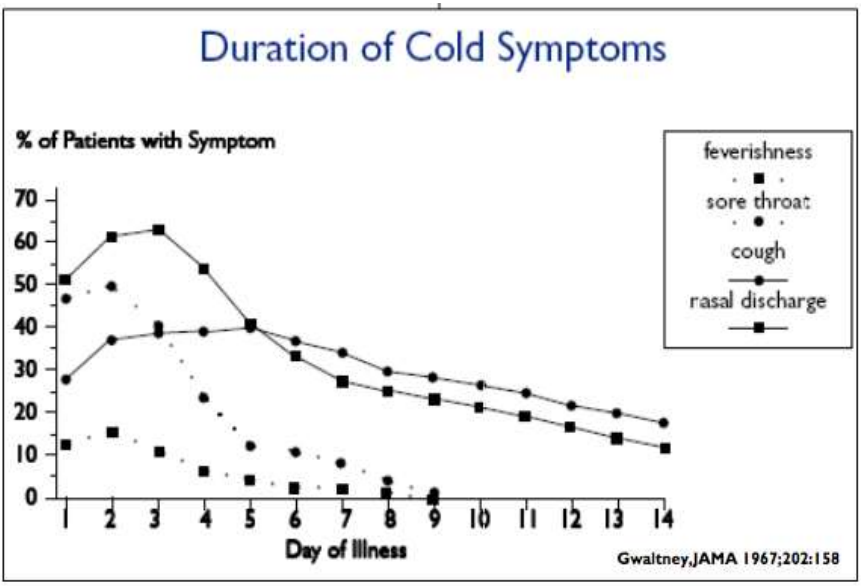
Weight	Dose	80 mg/ 0.8 mL	160 mg/5 mL	Chew or meltaway 80 mg	Chew or meltaway 160 mg
6–11 lb	40 mg	0.4 mL	1.25 mL		
12–17 lb	80 mg	0.8 mL	2.5 mL	1 tab	
18–23 lb	120 mg	1.2 mL	3.75 mL	1½ tab	¾ tab
24–35 lb	160 mg	1.6 mL	5 mL	2 tab	1 tab
36–47 lb	240 mg		7.5 mL	3 tab	1½ tab
48–59 lb	320 mg		10 mL	4 tab	2 tab
60–71 lb	400 mg		12.5 mL	5 tab	2½ tab
7-295 lb	480 mg		15 mL	6 tab	3 tab
>96 lb			20 mL		4 tab

IBUPROFEN DOSING

Age: over 6 months
These doses are given every 6–8 hours.
Do not exceed recommended doses!
(5 mL = 1 teaspoon)

Weight	Infant 50 mg/1.25 mL	Children's 100 mg/5 mL	Chewable 50 mg tabs	Chew tabs or swallow caps 100 mg
12–17 lb	1.25mL	1.25–2.5 mL		
18–23 lb	1.875mL	2.5–5 mL		
24–35 lb		5 mL		
36–47 lb		7.5 mL	3 tabs	1½ tabs/caps
48–59 lb		10 mL	4 tabs	2 tabs/caps
60–71 lb		12.5 mL	5 tabs	2½ tabs/caps
72–95 lb		15 mL	6 tabs	3 tabs/caps

ASPIRIN: ***Do not give your child aspirin*** unless specifically instructed by us.



RECOMMENDED RESOURCES

Reston Town Center Pediatrics
www.rtcpeds.com

For common questions about your child:
www.healthychildren.org

American Academy of Pediatrics
www.aap.org

Allergy and Asthma Network/Mothers of Asthmatics
www.aanma.org

C.H.A.D.D. (Children and Adults with ADD)
www.CHADD.org

National Asthma Education and Prevention Program
www.nhlbi.nih.gov

National Highway Traffic Safety Administration for car seat checks
www.nhtsa.gov

Positive parenting information:

- http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/

- www.loveandlogic.com

Vaccine information sites:

- Centers for Disease Control and Prevention
  http://www.cdc.gov/vaccines
- American Academy of Pediatrics
  http://www.aap.org/immunization
- Vaccine Education Center at Children's Hospital of Philadelphia
  http://www.vaccine.chop.edu

Facts for Families, American Academy of Child & Adolescent Psychiatry
www.aacap.org/cs/root/facts_for_families/facts_for_families

Potty Time
www.pottytime.com

SUGGESTED READING

American Academy of Pediatrics. *Caring for Your Baby and Young Child: Birth to Age 5; Caring for Your School-Age Child: Ages 5-1; Caring for Your Teenager*

American Academy of Pediatrics. *A Guide to your Child's Allergies and Asthma*

Bennet, Howard J. *Waking Up Dry: A Guide to Help Children Overcome Bedwetting*

Brazleton, T. Berry. *Touchpoints; Discipline: The Brazelton Way*; and *Toilet Training the Brazelton Way*

Briggs, Dorothy. *Your Child's Self Esteem*

Christophersen, Edward. *Little People*; and *Beyond Discipline*

Cline, Foster & Fay, Jim. *Parenting with Love and Logic*; and *Parenting Teens with Love and Logic*

Eisenburg, Arlene, Murkoff, Heidi, & Hathaway, Sandee. *What to Expect the First Year*; and *What to Expect the Toddler Years*

Faber, Adele & Mazlish, Elaine. *How to Talk So Kids Will Listen & Listen So Kids Will Talk*; and *Siblings Without Rivalry*

Ferber, Richard. *Solve Your Child's Sleep Problems*

Fraiberg, Selma. *The Magic Years*

Frost, Jo. *Supernanny: How to Get the Best from Your Children*; and *Ask Supernanny*

Garber, S. *Good Behavior*

Gordon, Thomas. *Parent Effectiveness Training*

Karp, Harvey. *Happiest Baby on the Block*; and *Happiest Toddler on the Block*

La Leche League International. *The Womanly Art of Breastfeeding*

Leach, Penelope. *Your Baby & Child*

Mohrbacher, Nancy & Kendall-Tackett, Kathleen. *Breastfeeding Made Simple: Seven Natural Laws for Nursing Mothers*

Offit, Paul A. *Autism's False Prophets*; and *Vaccines: What Every Parent Should Know*

Pantley, Elizabeth. *No Cry Sleep Solution*

Phelan, Thomas. *1-2-3 Magic*; and *More 1-2-3 Magic, Surviving Your Adolescents*

Pryor, Karen & Pryor, Gayle. *Nursing Your Baby*

Severe, Sal. *How to Behave So Your Children Will, Too!*

Siegel, Daniel & Payne Bryson, Tina. *No-Drama Discipline: The Whole-Brain Way to Calm the Chaos and Nurture Your Child's Developing Mind*

Siegel, Daniel & Payne Bryson, Tina. *The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind*

Spock, Benjamin. *Baby and Child Care*

St. James, Elaine. Simplify *Your Life With Kids*

Weissbluth, Mark. *Healthy Sleep Habits Healthy Child*
West, Kim. *Good Night, Sleep Tight*