Knoxville Pediatric Associates, P.C.

Pediatric Care

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CLINCH AVENUE LOCATION
2201 CLINCH AVENUE
KNOXVILLE, TENNESSEE 37916
PHONE (865) 525-0228
FAX: (865) 525-0285

CROSS PARK LOCATION
9017 CROSSPARK DR. SUITE 200
KNOXVILLE, TENNESSEE 37923
PHONE (865) 690-1161
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www.knoxpediatrics.com

KNOXVILLE PEDIATRIC ASSOCIATES, P.C.

MISSION STATEMENT

To preserve and improve our patient's quality of life through preventative and effective medical care; we will constantly work to ensure the care we give is appropriate and of the highest standards; and to be just in our dealings with patients, their families, our employees and ourselves.

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I. INTRODUCTION

Knoxville Pediatric Associates welcomes you to our group and we are happy that you have chosen us as your pediatricians. Our goal is to provide the best possible care for your child while building close doctor-patient relationships based on trust and compassion. Please feel free to let anyone in our office know if you experience problems or have suggestions for improvement.

This handbook is designed to give you an overview of how our practice works and to provide you with some basic medical information on common pediatric problems. We hope this will be helpful both to new patients in our practice as well as to any of our patients with problems which might necessitate a phone call to the office or doctor on call.

Our practice was originally formed in 1996 by the merger of two of the most well established pediatric practices in Knoxville, namely Knoxville Pediatric Group and Pediatric Associates of Knoxville. In 1998, the former Foothills Pediatric Group of Maryville joined. While the goals and philosophies of the three groups of physicians are the same, there remain some differences in practice styles between the three groups. For this reason, we have chosen to maintain the integrity of each of the three practices within the larger merged group. **In other words, patients will be identified as being seen at a particular location site: Clinch Avenue or Cross Park, Weisgarber Road or Farragut, and Foothills. It is not our intention for patients to be able to switch back and forth between the three physician groups. We feel this would be disruptive to continuity and would compromise our ability to deliver optimum care for your child.**

We currently have five office sites and over thirty physicians in our group. Please refer to the following individual location descriptions for more specific information regarding each site.

In 2007, all 5 of our offices transitioned to Electronic Health Records. We also have the capability to send prescriptions to pharmacies via e-scribe. We encourage you to visit our website at www.knoxpediatrics.com for information about each location, staff, forms, tips and resources.

CLINCH AVENUE LOCATION
2201 CLINCH AVENUE
KNOXVILLE, TENNESSEE 37916

Phone 865-525-0228
Fax: 865-525-0285
By Appointment only
Monday-Friday: 7:30 AM - 5:00 PM
Saturday: 7:30 AM - Noon
(Cross Park only)
Sunday: By Special Arrangement Only
(Clinch only)

Extra Charge Is Added for Sundays

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Our Clinch Avenue office is located near East Tennessee Children's Hospital and Fort Sanders Regional Medical Center (please see map inside back cover). Doctors and the nurse practitioners at this office see patients at our Cross Park office as well. By allowing your child to see different doctors, you have the advantage of knowing several doctors and the benefit of more than one opinion.If, on the other hand, you prefer to see a specific doctor, this can be arranged at the time you call for an appointment. At your visit, you should repeat your doctor preference when you check in and again when you are put in the exam room. When you specify a particular doctor, you may have a longer wait. The doctor of your choice may not always be working on the day you need to be seen, but we will make every effort to accommodate you.

For all life threatening emergencies, please call 911. For non-life threatening emergencies after regular business hours, please call our answering service at 970-1104. Your call should be returned within 1 hour. Please let the answering service know if your call is not returned in this time frame. Turn off your answering machine and leave your phone line clear so that your call can be returned by an East Tennessee Children's Hospital nurse.

CROSS PARK LOCATION

9017 CROSS PARK DRIVE, SUITE 200
KNOXVILLE, TENNESSEE 37923

Phone 865-690-1161
Fax: 865-531-8710
By Appointment only
Monday-Friday: 7:30 AM - 5:00 PM
Saturday: 7:30 AM - Noon
(Cross Park only)
Sunday: By Special Arrangement Only
(Clinch only)

Evening:
Night Clinic 5:00 - 8:00 PM
(Cross Park Only)
Monday - Friday

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Our Cross Park office is located at 9017 Cross Park Drive, Suite 200, near the Post Office (please see map outer back cover). Doctors and the nurse practitioners at this office also see patients at our Clinch Avenue office. By allowing your child to see different doctors, you have the advantage of knowing several doctors and the benefit of more than one opinion.If, on the other hand, you prefer to see a specific doctor, this can be arranged at the time you call for an appointment. At your visit, you should repeat your doctor preference when you check in and again when you are put in the exam room. When you specify a particular doctor, you may have a longer wait. The doctor of your choice may not always be working on the day you need to be seen, but we will make every effort to accommodate you.

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II. GENERAL OFFICE POLICIES / INFORMATION

IMMUNIZATION POLICY

At KPA we are committed to excellence in pediatric care. We are dedicated to preventing illness, suffering, and death. Due to recent controversies about vaccines, we have prepared a statement of our confidence in vaccine safety and effectiveness.

We believe in the effectiveness of vaccines to prevent serious illness and to save lives. We believe in the safety of our vaccines.

We believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Centers of Disease Control and the American Academy of Pediatrics.

We believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservation that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox .. .I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely

because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox, or know a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe and in the US have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of underimmunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe and the US over the past several years.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with your health care provider in advance of your visit. In some cases, we may alter the schedule to accommodate parental concern or reservations. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Knoxville Pediatric Associates.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

There is much information on the internet that is false and misleading. We suggest the following websites as reputable, accurate sites from which to obtain vaccine information: immunize.org and vaccine.chop.edu.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,

The Healthcare Providers of Knoxville Pediatric Associates, P.C.

HOSPITAL ROUNDS

We provide newborn care at these area hospitals:

Fort Sanders Regional Medical Center
Fort Sanders Parkwest Medical Center
Tennova/Physician's Regional Medical Center

We rotate hospital rounds between doctors in our group. One of our doctors will see your child every morning while in the hospital.

We consult neonatologists (newborn specialists) to evaluate sick or premature newborns and these infants may be transferred to an intensive care nursery at either East Tennessee Children's Hospital, University of Tennessee Hospital or Tennova/Physician's Regional Medical Center.

APPOINTMENTS

A receptionist will make appointments at the designated location after 7:30 a.m., Monday through Saturday. On Sundays, after 8 a.m., arrangements for sick children are handles by office staff through the answering service. Please advise he receptionist if the appointment is for a sick child, well baby check-up, recheck, physical exam or consultation. An appointment should be made for each child that is to be seen. By allowing us to schedule an appointment, waiting for everyone is greatly reduced and the office runs more efficiently.

The doctor on call cannot make appointments.

"Walk-ins" are strongly discouraged, and will be given an appointment at the next available time unless the child represents a true emergency. True emergencies will be seen immediately. We do not recommend walk-in clinics. We have appointments available 7 days a week. If you feel your child needs to be seen, please call us as soon as possible for an appointment. If it is after hours, we recommend you call our after hours number (865-970-1104). If it is necessary for your child to be seen after hours, we recommend you take your child to East Tennessee Children's Hospital.

If you need to cancel an appointment, we request that you give at least 24 hour notice for well visits and one hour notice for sick appointments. This will help us meet the needs of our other patients. Failure to cancel an appointment within the appropriate time frame will be considered "missed". Three or more missed appointments may result in dismissal from our practice.

PRESCRIPTION REFILLS

Please allow 24 hours for any non-urgent refills. Please make sure you know the name of the medication, the dose, the form (liquid or tablet) and the name and number of your pharmacy. A nurse may call you to discuss the refill if the patient has not been seen for regular check-ups or if the prescription needs to be adjusted.

To determine the cause of your child's symptoms and the appropriate treatment, it is in your child's best interest to be examined by a physician. Therefore, we only call in prescriptions for maintenance medications for chronic problems. We do not call in antibiotics for suspected infections.

TELEPHONE ADVICE

If your call concerns a life threatening emergency, such as a seizure or loss of consciousness, state this immediately to the first person who answers the phone. Our medical staff is trained and available to answer many of your questions over the phone such as whether or not an office visit is necessary, the correct dosage of medication or advice about minor illness. If a phone call is still needed from a doctor after speaking to one of our nurses, your call will be returned when the doctor is not with patients who are in the office. This may be after morning or afternoon hours.

Certain symptoms nearly always require a doctor's examination: earache, sore throat, skin rash, severe abdominal pain, painful urination or prolonged fever. Examination of your child is essential to make a proper diagnosis; therefore, we will not phone in an antibiotic without an evaluation in one of our offices by a doctor or nurse practitioner.

Discussions regarding school, emotional or behavior problems are best conducted by an appointment in the office. Telephone discussions are too often unsatisfactory. The doctor on call is available after hours to discuss only urgent or emergency problems. We understand that to parents any concern about their child can be considered urgent, but medication refills, feeding schedules, constipation and non-life threatening symptoms are better handles during regular office hours when your child's office chart is available. Our goal over the phone is to help you make decisions about your child, but we cannot diagnose and treat over the phone.

After regular business hours, your call will be answered by the After Hours Program at East Tennessee Children's Hospital. By asking you a series of questions, a pediatric nurse will assess the condition of your child and give you immediate detailed medical advice. The nurse may give you home instructions to follow, suggest you visit our office the next day or tell you to bring your child to the Emergency Department at Children's Hospital or another hospital near you.

ACCOUNTS AND INSURANCE

It is our objective to provide our patients with the best care at a reasonable cost. Inflation is growing for everyone including medical offices. today, we find ourselves confronted with ever-increasing costs for almost every supply and service we use in rendering professional care. Therefore, we request that all charges be paid at the time of service. For your convenience we accept VISA, Mastercard or Discover.

We participate with many HMO, PPO and POS insurance plans and we will file those insurance claims for you. Please remember that your insurance policy is a contract between you and your insurance company and we are not a party to the contract. Therefore, financial responsibility for you child(ren)'s treatment is ultimately yours. You are responsible for all copays and deductibles at the time of service. You will also be asked to complete a patient information form on a yearly basis which includes insurance information.

If you have a type of insurance with which we do not participate, it will be your responsibility to pay at the time of service. The receipt (superbill) you receive is coded for insurance purposes and may be submitted along with your claim form as well as used for tax purposes.

In a divorce situation, the parent bringing the child for the appointment is responsible for payment at the time of service. Any payment arrangement set forth in the divorce decree is between the parents and does not involve our office.

Coverage under your insurance plan may not coincide with the American Academy of Pediatrics guidelines which we support in our practice. This is particularly true for well-child care.

For specific questions or problems you may contact someone in our business office between 8:00 a.m. and 4:30 p.m. at (865) 525-0040.

PORTAL

KPA offers a Patient portal which is your online door to your Doctor's Office. You can request and manage appointments, update demographics and insurance information, view test results, request refills and ask non-urgent nurse questions all at your convenience. We urge you to use this convenient service which is available on internet-enabled devices. Let us know if you would like an email invitation to get started.

BOOKS WE RECOMMEND ON CHILD CARE

GENERAL PEDIATRICS

- Your Baby's First Year by Steven Shelov, MD
- Caring for Your Baby and Young Child: Birth to Age Five by Steven Shelov, MD
- Caring for Your School Age Child Ages 5 to 12 by Steven Shelov, MD
- Caring for your Teenage by Steven Shelov, MD
- Your Child's Health: The Parents' Guide to Symptoms, Emergencies, Common Illnesses, Behavior and School Problems by Barton Schmitt
- American Academy of Pediatrics Guide to Your Child's Symptoms: The Official Home Reference, Birth Through Adolescence by Donald Schiff, MD (Ed)

BREASTFEEDING

- The American Academy of Pediatrics New Mother's Guide to Breastfeeding by Joan Younger Meek
- The Nursing Mother's Companion by Kathleen Huggins
- The Breastfeeding Book: Everything You Need To Know About Nursing Your Child From Birth Through Weaning by Martha and William Sears
- So That's What They're For: Breastfeeding Basics by Janet Tamaro

VACCINE INFORMATION

- What Every Parent Should Know about Vaccines by Paul Offit and Louis Bell, MD
- Six Common Misconceptions and How to Respond to Them

NUTRITION

- American Academy of Pediatrics Guide to Your Child's Nutrition: Making Peace at the Table and Building Healthy Eating Habits for Life by William Dietz (Ed.)
- Coping with a Picky Eater: A Guide for the Perplexed Parent by William G. Wilkoff
- Secrets of Feeding a Healthy Family by Ellen Satter
- Food Fights by Laura Jana & Jennifer Shu

SLEEP

- Guide To Your Child's Sleep: Birth Through Adolescence by George Cohen, MD
- The Happiest Baby on the Block: The New Way to Calm Crying and Help Your Newborn Baby Sleep Longer by Harvey Karp
- Solve Your Child's Sleep Problems by Richard Ferber

PARENTING AND DISCIPLINE

- The Happiest Toddler on the Block: The New Way to Stop The Daily Battles of Wills and Raise A Secure and Well-Behaved One-to-Four Year Old by Harvey Karp and Paula Spencer
- Discipline Without Shouting or Spanking by Wykoff and Unell
- PET: Parent Effectiveness Training by Thomas Gordon
- Making Children Mind Without Losing Yours by Kevin Leman, MD

III. NEWBORN CARE

INSTRUCTIONS FOR NEWBORN CARE

During the next few days, most of your time will be spent in resting and regaining your strength. You can put this time to good use by getting to know some of the simple things which will help to make life with your baby easy and fuss-free.

Parenthood is one of the most exciting experiences you will ever have, but is it also a bit frightening, especially if you are a parent for the first time. We will assist you in gaining confidence in your parenting skills here in the hospital and also during the first weeks and months at home. We encourage you to read this booklet and discuss any questions you have at our daily hospital visits. We also encourage you to remember to nurture your family relationships as this is also important to the health and happiness of your baby.

You will quickly discover that your baby has a unique personality just as every adult does. Some babies are quiet, docile and even tempered. Others are irritable, always hungry and poor sleepers. Most are between these extremes.

We view our main job as that of educating you in the science and art of parenting. In our well baby visits, the doctor and nurses will cover aspects of feeding, discipline, safety and disease prevention as they apply at different ages.

OFFICE VISITS

Your baby should have the first office check-up at 3 or 5 days of age. You will be seen in the hospital by the doctor assigned for hospital rounds. You should schedule your first office visit as directed by that doctor. It may be the next day following discharge or up to 5 days later depending on the length of your hospital stay and presence of jaundice or feeding problems. After discussion with the doctor in the hospital, please call the office for an appointment. You do not necessarily have to see the doctor that you saw in the hospital.

Along with the check-up examination we will want to discuss your baby's growth, development and the many interesting things that you can expect your baby to do within the next few months.

Be sure to bring along extra diapers and a bottle of formula (if bottle feeding) when you come to the office.

IMMUNIZATIONS

Immunizations (baby shots) are very important and it is highly recommended that your baby receive Hepatitis B vaccine while still in the hospital. Your baby will then receive the first “set” of immunizations at 2 months of age. A complete immunization schedule will be given to you at the first office check-up.

JAUNDICE

Jaundice is a condition that commonly occurs in newborn infants. Jaundice is a French word that means "yellow" and it describes the yellow color of the skin. There may also be yellowing to the whites of the eyes. Jaundice usually appears on the second or third day of life and often disappears in about a week. As many as two-thirds of infants may have jaundice because jaundice occurs when the liver is not fully mature. The liver ordinarily rids the blood of a substance called bilirubin. When new red blood cells are created, the old blood cells release bilirubin which is removed from the body by the liver. When the liver is not fully mature, it does not function properly and the bilirubin tends to build up in the baby's blood. Because bilirubin is yellow, it causes the skin to become yellow as well. This condition is known as jaundice. More serious types of jaundice can occur when the baby's blood type is different from the mothers. If jaundice is more severe or if the level of bilirubin gets too high, treatment will probably be necessary. A technique called phototherapy is used. Phototherapy is a treatment using special light therapy. These lights cause a chemical reaction to occur that hastens the removal of bilirubin from the body. These high intensity lights are placed over the baby. the baby is kept warm and has protection from the lights over his/her eyes. This is done either in the hospital or by special arrangement with a home health nurse. Sunlight or the lights you have at home DO NOT HAVE enough of the correct intensity to help lower the bilirubin level. The phototherapy is continued until the bilirubin drops to a safe level. The level is checked by testing a sample of blood. For reasons that are unclear, excessive jaundice sometimes occurs in breastfed babies. If your baby is even slightly jaundiced at the time of discharge, we require you to come back to the office in a day or two to have a bilirubin level checked. If the level has risen significantly, this may mean that the baby may need to receive phototherapy. Phototherapy can frequently be done at home.

SIGNS & SYMPTOMS OR NEONATAL INFECTION FOR MOTHERS WHO HAVE POSITIVE TESTS FOR GROUP B STREPTOCOCCUS

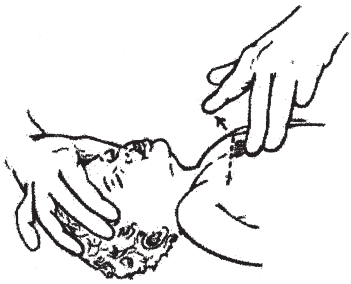
Group B Streptococcus is a major cause of bacterial infections in women and newborns at the time of delivery. Group B Streptococcus is a bacteria that is occasionally found in the vaginal tract of some women. Many women are tested for this bacteria several weeks before they deliver their infants. Those women found to harbor this bacterium are then given antibiotics at the time that they deliver their infants. These infections include pneumonia, meningitis, and blood poisoning (bacteremia) of the infant. If a mother has been found to have this bacteria and has been treated with antibiotics before she delivers her child, the child's risk for these infections is greatly diminished.

Infants exposed to this bacteria, (whether their mothers have been treated with antibiotics or not) should be watched closely for the first few days to months for signs of infections. This is especially important during the first 7-10 days of life (early onset disease) and 4-6 weeks of age (late onset disease). These signs include fever (temperature greater than 100.4 degrees F), lethargy, irritability, difficulty feeding, vomiting, grunting, difficulty breathing, or bulging soft spot (fontanel). These newborns are monitored in the hospital for this infection for 48 hours after birth. These are just a few of the signs and symptoms an infant with Group B Streptococcal infection may manifest. If you have any concerns that your newborn is "not acting right" please notify our office promptly. Also please notify your child's doctor if you (the child's mother) had a positive Group B Streptococcal culture during your pregnancy.

IV. SAFETY

Infant CPR

1. **Check for a response:**
   - If the infant is not moving or breathing gently tap or stroke the infant's foot and shout "Are you okay?" **DO NOT SHAKE THE INFANT!**
2. **Shout for help!**
   - If the infant does not respond, shout for help.
   - If help arrives send that person to phone 911 or your emergency response number for help.
3. **Place the infant on a firm flat surface.**
   - A table, countertop or floor would work. Do not leave the infant unattended.



4. **If the infant does not respond and is not breathing: Begin chest compressions. Push Hard and Fast**
   - Give 30 compressions (pushes) at a rate of 100 per minute followed by 2 breaths.
   - **Compressions (pushes)** should be done on bare chest.
   - Place 2 fingers in the middle of the chest just below the nipple line.
   - Be careful not to press on the bottom or the tip of the breastbone.
   - Press the chest downward about 1/3 the depth of the chest.
   - Give 5 cycles of **30 compressions (pushes) and 2 breaths**. (about 2 minutes)

5. **Give 2 breaths**.
   - If the baby is not breathing you will need to breathe for the infant.
   - Cover the infant's mouth and nose with your mouth.
   - Give one breath over 1 second.
   - You should feel the air go in and see the chest move.
   - Give a second breath.
   - If the breath does not go in, open the airway by repositioning the head.
   - Try again to give the breath.
   - **The Goal is to deliver 2 effective breaths with CPR!**
6. **If you are alone, phone 911 or your emergency number after you have done 5 sets of 30 compressions (pushes) and 2 breaths. (This will take about 2 minutes).**
   - You may carefully carry the baby to the phone if there are no signs of injury.
7. **Resume CPR as soon as possible!**

8. Continue giving sets of 30 compressions (pushes) and 2 breaths until emergency personnel arrive and take over.
9. If the baby begins to breathe, do not cancel the 911 call, but continue to monitor the baby's breathing.

Choking

If something becomes lodged in the baby's airway the baby cannot breathe. You must act quickly to get the object out by using **back slaps and chest thrusts.**

1. **Signs of severe or completely blocked airway.**
   - The baby can't make any normal sounds, no talking, no loud crying though you might hear some tiny squeaks.

2. **Remove foreign body airway obstruction.**
   - Place the baby in a head down position over your forearm. Rest your arm on your upper leg. Support the head and jaw with your hand.
   - Give the baby up to **5 back slaps** between the shoulder blades.
   - If the object is not removed after 5 back slaps sandwich the baby between your two arms and turn on his back.
   - **Give up to 5 chest thrusts.** Push in the same place you push for CPR.
   - Repeat giving **5 back slaps and 5 chest thrusts** until the object comes out and the baby can breathe, cough, or cry.
   - If the baby becomes unresponsive, move quickly to begin CPR.

See Red Cross, Green Cross or
American Heart Association For Training Courses
YouTube Videos - Training Class Information

Notes / Phone Numbers:

TRANSPORTATION

An infant car seat should be used at all times in the rear-center passenger seat, even for the baby's ride home from the hospital. Infant car seats are designed to be rear facing and must be used until until your child is two years old. The infant, semi-reclined, is secured in the seat with a harness, and the seat is secured to the vehicle with a lap belt. There are also convertible seats which may be converted from an infant seat to a toddler seat to accommodate children from birth to 40 pounds.

The use of infant car seats is required by the law in Tennessee. Do not confuse approved, sturdy child restraint devices with bouncy seats or shopping carriers. Be mindful of your own vehicle's recommendations regarding the use of car seat positioning and airbags. The Knox Country Health Department is an excellent resource for questions about car seat positioning at 865-215-5150. (**Guidelines change frequently-please ask for a car seat guide, if needed.**) We have a list of car seats recommended by the AAP in our office.

You should never place your infant alone on a sofa, bed, or other high place unprotected. We see numerous accidents that have occurred while a baby is in a "walker" and we prefer that they not be used. Baby walkers are the most common cause of head injuries in infants and are highly discouraged by the AAP.

INFANT SLEEPING POSITION AND SIDS

At first the baby will eat, then soon afterwards go to sleep. Recently the Academy of Pediatrics has recommended positioning an infant on his/her back to decrease the risk of SIDS (Sudden Infant Death Syndrome). The mattress should be flat with no bumper pads in the crib. A waterproof cover may be used to protect the mattress. No pillow, blankets or quilts should be used. The AAP recommends using one piece sleepers instead of blankets. Do not wrap or "swaddle" or overdress the baby because this interferes with his/her arms and legs. From the first, you baby should go to sleep on his/her own, that is without rocking, patting, or singing. These measures should not be used to get an infant to sleep because they are extremely difficult to stop later. A night light is optional, but remember this would be difficult to discontinue later. The average age for sleeping through the night is about 4 months and for the most part is unrelated to feedings.

Parents and caregivers should place their healthy infants on their backs when putting them down to sleep. This is because recent studies have shown an increase in Sudden Infant Death Syndrome (SIDS) in infants who sleep on their stomachs. There is no evidence that sleeping on the back is harmful to healthy infants. Do not place your infant to sleep on waterbeds, sofas, soft mattresses or other soft surfaces. Pillows, quilts, comforters or sheepskins should not be placed under your baby.

- Devices designed to maintain sleep position or to reduce the risk of rebreathing are not recommended since many have not been tested sufficiently for safety. None have shown to reduce the risk of SIDS.
- Do not smoke during pregnancy; continue to provide a smoke-free environment for your baby.
- Make sure your baby does not get overheated. Keep the temperature in your baby's room so it feels comfortable for an adult and dress your baby in as much or little clothing as you would wear.
- A certain amount of "tummy time" while the baby is awake and observed is recommended for developmental reasons and to avoid flat spots on the head.
- Although the recommended sleep position is on the back, it is important that your baby spend some of his or her waking hours in the prone position (on the tummy). This is beneficial for your baby in that it helps neck and shoulder muscles to develop and is in no way harmful for your baby. Remember: “back to sleep, prone to play”.

ILLNESS

During the first 3 months of life, it is especially important for you to recognize symptoms of illness in your infant; excessive irritability, refusal of feeding and, most importantly, a rectal temperature over 100.4 degrees. While your baby is young, to help prevent illness, it is advisable to avoid large crowds (malls, amusement parks, church nurseries). People are interested in your baby and want to hold and hug. Washing hands prevents the spread of germs and should be encouraged before visitors hold your child. Persons who have colds or other illnesses should be asked to visit later when they are well.

EMERGENCIES

For all life threatening emergencies call 911. Should a non-life threatening emergency rise, call us immediately. One of us is always available. If you receive no answer at the office, call the designated after hours office

number (970-1104) and the doctor or nurse on call will be paged and call you back as soon as possible. After office hours, please limit calls to emergencies. It will be greatly appreciated if formula changes and routine questions would be limited to regular office hours.

FEEDING

Feeding is one of your baby's first pleasant experiences. The baby's first love for its parents arises primarily from the feeding situation. At feeding time your baby receives nourishment from food and also nourishment from mother and father's love. The food, correctly taken, helps the baby to grow healthy and strong. The parents' love, generously given, helps the baby feel secure. Help your baby get both kinds of nourishment.

Both of you should be comfortable. Choose a chair that is comfortable for you. This will help you be calm and relaxed as you feed your baby. Your baby should be warm and dry so that baby is comfortable too.

Hold your baby in your lap, with the head slightly raised, and resting in the bend of your elbow. Whether breastfeeding or bottle feeding, hold your baby comfortably close.

FOR BREASTFEEDING:

The most important keys to successful breastfeeding are confidence, practice and relaxation. Breastfeeding is a learning experience for both you and your baby. If you are relaxed, your baby will pick up on your cues and will nurse better. Nursing should begin early in the first day of life and ideally within an hour from the time of birth. Rooming-in is helpful in that the baby can be fed "on demand" (but at a minimum of every 2-3 hours) instead of waiting for a scheduled "feeding time". Cues that your baby is hungry include opening his mouth and sticking out his tongue while turning his head to either side, sucking on his hands, and gentle stretching of his arms and legs.

Many first-time mothers feel that they do not have any milk. In fact, you do! Colostrum is a clear or yellow fluid that is produced in the first few days. It is produced in small quantities but contains protective white blood cells that are important in fighting infection. It is an ideal food for newborns because it is easy to digest and stimulates the baby's first bowel movement.

Newborns do not need any fluids other than colostrum (the exception is the baby with low blood sugar). Supplemental feedings of water or formula may cause the baby to lose interest in the breast and to nurse less frequently

than needed. Supplemental water may also cause an electrolyte imbalance. Bottle feeding and breastfeeding require different types of sucking. For the breastfeeding baby, bottle feeding may (1) lessen the baby's instinctive efforts to open her mouth wide, (2) condition her to wait to suck only when she feels a firm bottle nipple in her mouth, and (3) encourage her to push her tongue forward which is the opposite of what she needs to do for nursing. The baby who has been bottle fed may also become frustrated while nursing, since milk does not flow as rapidly from the breast as it does from a bottle. For these reasons, we recommend that you delay introducing a bottle and pacifier until your baby is 3 to 4 weeks of age, when breastfeeding is second nature for your baby and your milk supply is established.

GETTING STARTED: For most women, sitting up in bed or a comfortable chair is easiest for breastfeeding. Make sure you are relaxed before you put your baby to your breast. Use pillows on your lap, under you arms and behind your back. Putting your feet on a footstool to raise your knees slightly above your hips will eliminate back strain.

Make sure your baby is comfortable and feels secure and supported. Nestle your baby in your arm at the level of your breast. You may use the cradle or cross-cradle hold. Two alternative positions are the football hold and lying down. These positions are especially helpful if you have had a Cesarean section. The baby should be turned toward you, chest to chest with his head and trunk in a straight line so that he doesn't have to strain and turn his head to attach to your breast. Tuck your baby's lower arm around you. If necessary, hold his upper arm gently with the thumb of your supporting hand. Be careful not to tilt his head as it will be difficult for him to swallow in that position. A very slight extension of his head with his chin touching your breast will help keep his nose clear.

Hold your breast with your fingers underneath and thumb on top, making sure all of your fingers are placed well away from your areola. It is sometimes helpful to roll your nipple between your fingers for a few seconds to help it become more erect. Then manually express some colostrum to entice your baby to take your breast.

Gently tickle your baby's lower lip up and down with your nipple to encourage him to open his mouth wide. Be patient! The moment he opens wide, almost like a yawn, quickly pull him close to you. Do not lean forward, trying to put your breast into his mouth. Instead, pull him toward you so that he has a large mouthful of breast, including the areola. He is latched on well if his lips are flanged (upper lip is turned upwards and lower lip is turned downwards) and his nose and chin are touching your

breast. Do not worry that your baby cannot breathe in this position. His nostrils are shaped to allow adequate breathing while nursing.

Breastfeeding should not be painful. If you feel any pain after your baby starts sucking rhythmically, stop and break the suction by inserting your finger into the corner of his mouth between the gums and slowly easing your nipple out of his mouth. Then try again. Don't be discouraged! Latching-on may take several attempts. Latch-on discomfort is common in the first few days but any pain should subside in a few seconds.

For the first 10 to 14 days, try to breastfeed every 2 to 3 hours during the day (times from the beginning of one feeding to the beginning of the next) and every 3 to 4 hours at night. Try to nurse for 15 to 20 minutes on each side. Burp the baby after each side and if he is sleepy, change his diaper or expose him to air to arouse him for the second side. Begin the next feeding on the side you ended on. After 2 weeks, let him nurse until the first breast is empty and then finish off on the second breast to ensure he receives your rich hindmilk. Your baby is finished on the 1st side when he/she comes off the breast after 10 minutes of constant swallowing or falls asleep. You should hear swallowing and notice that your breasts are softer after nursing.

Be sure to rotate positions to empty all ducts and to prevent sore spots. Air dry nipples 5 to 10 minutes after each feeding. You may use expressed breastmilk or modified lanolin (Lansinoh) on your nipples. If you use lanolin, do not apply it to the face of the nipple as this may plug the milk ducts and result in mastitis.

Keep a record of your baby's feedings, wet diapers, and bowel movements for the first 2 to 3 weeks or until your baby has had appropriate weight gain and your milk supply is well established. Most babies lose 5 to 10% of their birth weight within the first couple of days. It usually takes 1 to 2 weeks to regain the birth weight. By at least 2 weeks, most babies gain 4 to 7 ounces per week for the next few months.

Your baby should have at least 1 wet diaper on day 1, 2 to 3 wet diapers on day 2, and 3 to 4 wet diapers on day 3. Your milk will come in around the 3rd to 5th day. When your milk comes in, you should see 6 to 8 wet diapers per day. The stools on the first few days will be tarry and black (meconium) but should become liquid, yellow, seedy stools after your milk comes in. Your baby usually will have several bowel movements per day but some babies go 3 to 4 days in between stools when they are several weeks old.

How to know if your baby is getting enough milk:

1. Has 6 to 8 wet diapers each 24 hours after 4 days of age.
2. Has 1 to 2 bowel movements each day.

3. Takes some 2 hour naps and acts content after most nursing sessions.
4. Mother's breasts are softer because milk was removed during nursing.
5. You can hear baby swallowing during feedings.
6. Baby begins gaining weight in the second week of life at a rate of 4 to 7 ounces per week.

FOR BOTTLE FEEDING:

When choosing to bottle feed, there are a variety of commercial formulas available. Unless otherwise specified, continue to feed your infant the formula which was begun in the hospital. There are now many advertisements and coupons for infant formulas. We ask that you disregard these, unless they are for an approved formula. If you have questions about infant formulas and particularly if you feel you should change your baby's formula, we want to discuss your questions. We recommend formulas which are best suited for your baby's nutritional needs and should be continue until we tell you otherwise. The formulas we recommend are all iron fortified. Babies must have iron in small amounts. Without this small amount (11-12 mg./day) of iron, red blood cells will not develop and your baby will become anemic. This amount of iron will not cause abdominal pain, colic, gas, vomiting, diarrhea, or constipation.

The formulas are available in 32-ounce cans of ready to feed, 13-ounce cans of concentrate, or 16-ounce cans of powder. The ready to feed is poured directly into the bottle. The concentrate is mixed with 13 ounces (equal parts) of water. The powder is mixed in 2 ounces of water and 1 scoop of powder. This ratio is very important and should not be altered.

Bottles and nipples should be thoroughly cleaned in a dishwasher prior to preparation. STERILIZATION OF WATER IS NOT NECESSARY UNLESS WELL WATER OR SPRING WATER IS USED. Follow manufacturers instructions for care of bottle and bottle nipples.

It can be dangerous to heat a bottle in the microwave because the milk heats quickly and unevenly. We highly recommend not using this method of heating.

Either disposable plastic bag nursers or glass bottles should be used. Any nipple that is comfortable to the baby is acceptable. The nipple holes must be large enough to allow milk to come out rapidly in drops but not in a constant spray or stream.

Seated comfortably and holding your baby, hold the bottle so that the neck of the bottle and the nipple are always filled with formula. This helps your baby get formula instead of sucking and swallowing air. If the baby doesn't waste energy sucking air, enough formula will more likely be taken. Air in the stomach may give a false sense of being full and may also cause

also cause discomfort.

Your baby has a strong natural desire to suck. Sucking is part of the pleasure of feeding time. Babies will keep sucking on nipples even after they have collapsed. So take the nipple out of your baby's mouth occasionally to keep the nipple from collapsing. This makes it easier to suck, and lets the baby rest a bit. (Be sure to follow our instructions about nipples.)

Never prop up the bottle and leave your baby to feed himself. The bottle can easily slip into the wrong position. Remember, your baby needs the security and pleasure it gives to be held at feeding time. It's a time for you and your baby to relax and enjoy each other. He/she should be held for bottle feeding as long as he/she is on the bottle.

The amount of formula your baby takes will vary. Babies have a right not to be hungry sometimes, and you cannot make a baby want to eat. Most babies feed for 15 to 20 minutes. The newborn generally takes from one-half to two ounces every three or four hours, gradually building up to three to six ounces by one month. When your baby takes all of his/her bottle, yet cries for more, or if he/she wants to feed every two hours instead of his/her usual three or four, then it is time to change the amount in each bottle.

A SCHEDULE WITH FLEXIBILITY:

Feeding schedules are usually most satisfactory if the hours are set roughly and the baby is allowed to eat when hungry....for example, anytime between three and five hours after the last feeding. New babies usually need to be fed about every 3-4 hours if formula fed.. Breastfed babies may nurse every 2-3 hours. Should he/she occasionally wake up and cry less than two hours after a feeding, he/she is probably not hungry. However, should he/she consistently waken and cry less than two-and–a-half hours after feeding, the amount of formula or breast milk may be insufficient.

Remember your baby will cry for different reasons and may not necessarily be hungry. Though he/she will suck when given a bottle at this time, sucking is one way the baby has to soothe himself. Gradually, as you learn the difference between a hunger cry versus a mad cry or a wet or dirty cry, you will be able to mold baby's feeding times to fit your own needs.

"BURPING":

"Burping" your baby helps remove swallowed air. Even if fed properly, both bottle-fed and breastfed babies usually swallow some air. The way to help your baby get rid of this is to "burp" or bubble him or her. Hold baby upright over your shoulder, and pat or rub the back very gently until he or she lets go of the air, or place him or her down over your lap and gently rub the back.

Your baby can also be "burped" by holding him or her in a sitting position (baby leaning slightly forward) on your lap, with your hand supporting the head.

It isn't always necessary to interrupt a feeding to "burp" your baby, but always do it after each feeding. Of course, sometimes your baby may not "burp" because he or she doesn't need to. So don't try to force him or her.

WATER:

Water is not necessary or recommended for infants under 6 months of age.

VITAMINS:

Vitamins will be started according to your baby's needs. Infant formulas have vitamins added, therefore vitamin supplementation is not needed. Following the AAP guidelines, we recommend that all breastfed babies receive vitamin D supplementation. Inadequate body stores of vitamin D can lead to a condition called nutritional rickets in which abnormal bone development can occur. Children at the greatest risk are those with darker skin, those who spend little time outdoors, solely breastfed infants and older children who do not drink vitamin-D fortified milk. You may use D-Vi-Sol or Trivisol drops that are available over the counter. The dosage is one dropper per day. Please talk to your doctor if you have more questions.

SUPPLEMENTAL FOODS:

The AAP recommends exclusive breastfeeding until 4-6 months to achieve full benefit of maternal antibodies and prevention of food allergies. Formula or breast milk is nutritionally adequate for your baby until six months. An occasional infant becomes dissatisfied with breast milk or formula alone prior to three or four months of age. Please discuss supplemental feeding with the office nursing staff if you feel it is needed. Plain rice cereal diluted with water, formula, or expressed breast milk can be given once or twice daily, in amounts of one or two tablespoons, given with a baby spoon. Do not use a syringe type feeder or "infant feeder". These may be very dangerous and should not be used.

SKIN CARE

BATHING:

It's good to have a fairly regular time for bathing your baby. The room should be warm, with no drafts on baby. Keep bathing supplies together to save yourself steps. Until the navel (and circumcision) is healed, wash your baby by sponging. Afterwards you can use a tub or bathinette. Test the water temperature with your hand first. Daily bathing is unnecessary. We prefer Ivory or Dove instead of baby soaps or washes.

FACE: Wash with plain water and soft cloth and no soap.

EYES: To clean eyes, use plain water and a wash cloth.

EARS: Do not clean deeply because this packs the wax further back in the ear canal. Only wipe the outside of the ear with a moist cloth. If your baby seems to have an excessive amount of earwax, ask us what you should do.

HEAD: Lather the head with "no tears" baby shampoo. The fontanels (soft spots) should also be washed. If flakes or greasy, scaly cradle cap develop, then you should gently scrub the head with a soft baby hairbrush or baby wash cloth. If the cradle cap persists, we recommend using mineral oil or baby oil should be substituted.

FINGERNAILS: A newborn's fingernails are soft initially, but harden quickly. We recommend using baby nail clippers to trim the nails. We DO NOT recommend biting off the nails in order to avoid risk of infection. Nail clipping may be best performed with two people - one person to hold while the other person clips. It may also be helpful to clip nails while your baby is sleeping or feeding.

VAGINA: Clean gently with plain water and a cotton ball. Wipe this area from front to back to avoid the introduction of stool into the urethra. Use soap only if there is drainage or odor and always rinse thoroughly. It is normal to see discharge or a drop of blood in the first few weeks of life.

CIRCUMCISION: Clean with soap and water daily or as needed if soiled by stool. If there is mucus or blood drainage, petroleum jelly should be used to prevent sticking to diapers while healing.

NAVEL: Keep the diaper folded below the navel so that it can stay relatively dry. Sometimes after the cord falls off there may be a few drops of blood, but this is no cause for worry.

DIAPER AREA: Change your baby's diaper as soon as possible after bowel movement or wetting. Wash with washcloth, soap and water, rinsing well and patting dry. You may use disposable diaper wipes, but they occasionally cause irritation. Wet gauze is an alternative. Normally, diaper creams are not necessary. Powder should not be used as the baby may inhale it. If needed, we recommend Balmex, Desitin or Triple Paste.

SKIN PROTECTION: Lotion should be used sparingly only if skin is cracked or peeling. Curel, Lubriderm, Moisturel, Keri, Aveeno, or CeraVe are recommended. Please ask about all other creams, lotions, and oils. We do not recommend "baby" lotions, oils or powders.

HEAT RASH: (also called prickly heat) This is largely avoided by not over dressing. Undershirts are seldom necessary and certainly not in the summer. Also, switching detergents, soaps, or diapers can sometimes cause rashes.

COMFORT

CLOTHING:

Usual indoor dress should include only a diaper and a gown or one piece stretch suit. Socks, sleepers, and undershirts can be added in the winter. The best materials are cotton and cotton-polyester blends. During the first six months, washing with Ivory or Dreft is preferable to harsher detergents. Avoid using dryer sheets. In an automatic washing machine, normal washing procedures may be used with a mild soap or detergent. Disposable diapers may be used, and are more convenient, but also more expensive. Some babies may be allergic to certain brands of disposable diapers.

ENVIRONMENT:

Try to keep an even, comfortable temperature in the baby's room. On hot days provide ventilation. On cold days check on your baby occasionally to see that he/she is covered enough to be warm and comfortable. An environment free of tobacco smoke is healthier for your infant. You should avoid exposing a young infant to people with infectious diseases.

OUTDOORS:

Young babies and children are encouraged to be outside. In the winter, especially when very cold and windy, heavy blankets and caps are advisable. During the warm months, care should be taken to avoid sunburn and to maintain adequate fluid intake. Short sun exposure in midmorning and later afternoon is advised, starting with only ten to fifteen minutes per day. Long term exposure to the sun should be avoided. Sunscreen should be used after 6 months of age. Mosquito repellent containing DEET can be used as early as 2 months of age.

BABIES ARE BABIES

Although your baby will spend most of his/her day sleeping and eating, a number of other fascinating behaviors will also occur.

All babies sneeze, yawn, belch, have hiccups, pass gas, cough, and cry. They may occasionally look cross eyed.

BREATHING: Babies have irregular breathing patterns, frequently panting rapidly, then stopping altogether for several seconds. This is called periodic breathing. Be reassured this is normal.

HICCUPS: These are spasms of the diaphragm. They are harmless and do not cause pain for the baby. No treatment is needed for hiccups.

COUGHING: This is how the newborn clears the throat of mucus. Occasional coughs do not indicate a cold.

SNEEZING: This is how the baby cleans his/her nose of mucus and debris. Occasional sneezes do not indicate a cold. The baby's nose often seems stuffy during the first several months of life, especially if he/she is born in the fall or the winter. This is due to trapped mucus partly blocking his/her very small nasal passages. A cool room and occasional use of a cool mist room humidifier will help.

PASSING GAS: This is always normal unless accompanied by severe pain or constipation (hard, infrequent stools).

STOOLING: This occurs very often at first, frequently with each feeding, then gradually decreases with time. The first stools are black and smelly,

changing by age two or three days to normal stools. A normal formula stool is yellow, brown, or green and mushy. A breast milk stool is loose, full of mucus and curds and is yellow or light brown. Formula babies stool from one to five times per day while breast-fed babies stool somewhat more often. Straining is normal. Unless stools are rock hard or are liquid, they are probably normal. Some babies do not stool every day but may go two or three days between stools.

SPITTING: All babies spit (or burp) some formula or breast milk from time to time. It decreases with age. During the first several days of life, the baby may normally spit up phlegm or mucus that was not expelled during the delivery process. However, forceful vomiting is abnormal and should be reported to us. It is often helpful to keep your baby upright on your shoulder for 15-20 minutes after feeding.

SEEING: Newborns can see well enough to prefer watching a face or bright colors rather than blank walls. Occasionally, they look "cross-eyed". This is normal up to three months of age. If it persists after this time or if your baby does not appear to look with both eyes, be sure to mention this to the doctor.

HEARING: Most newborn babies prefer quiet environments. By 3 months of age you should feel that your baby hears you. Tell us if you cannot be certain.

CRYING: Crying is the baby's way of saying he/she is hungry, wet, dirty, thirsty, hot, cold, sick, sleepy or bored. You will gradually learn to know what your baby's different types of cries mean. Even a perfectly healthy baby will probably cry for a while each day without apparent reason. He/she will do himself/herself no harm. As a matter of fact, the baby's crying time can equal up to 3 hours in a 24 hour period.

V. COMMON CHILDHOOD ILLNESS REFERENCE

Management of Fever

Fever is a symptom, not a disease. It is usually a sign of infection. Fever is part of your child's defenses against infection, helping to "burn out" the germ causing bacteria.

When your child has an infection, antibiotics may be required, but only if the infection is caused by bacteria. Fever is more often caused by viruses than by bacteria.

Infants and children frequently get temperature elevations as high as 104 degrees Fahrenheit (40 degrees Centigrade). This degree of fever is not harmful in itself and is **NOT** a medical emergency.

Temperatures taken by ear probes and temporal (forehead) probes are not as reliable and we urge you not to use them. Digital thermometers are inexpensive and are very accurate. The most accurate temperature is taken **rectally**. An axillary temperature (taken high up in the child's armpit) is an acceptable alternative. The oral (mouth) temperature is best only in children over four years of age. It is inaccurate if liquids have been taken recently, whether hot or cold, if the mouth is open or if your child cannot hold it under the tongue.

When reporting fever to our nurses or doctors, please **DO NOT** add or subtract degrees because it is very confusing. Just be sure to take the temperature accurately and report which method was used.

If your child has fever, there are several things you can do to help relieve discomfort:

1. Give plenty of cold fluid (juices, diluted Gatoraide or Poweraid, popsicles, Jello, tea, ice chips, etc.). Appetite for food is usually decreased with fever but should improve when the child begins to feel better.
2. Dress your child lightly and remove all tight fitting clothing. Bedclothes should also be light.
3. Fever reducing agents (acetaminophen or ibuprofen) can be used. Remember that your child will usually have a fever for 2-3 days with most illnesses even if antibiotics and other measures are used. After your child has been examined by the doctor and treatment has begun, if he/she becomes quite ill with difficulty breathing, extreme sleepiness, severe vomiting or other symptoms not anticipated by the doctor, we should be notified again.

We do not recommend aspirin with fever due to the possibility of developing Reye syndrome.

4. If the fever is over 104 degrees, in addition to fever reducing analgesics, you can sponge with water that is lukewarm (neither hot or cold). Rub the skin briskly with a washcloth, especially in the area of the armpits, back and groin or place the child in a tepid bath. We do not recommend bathing with rubbing alcohol.
5. **REMEMBER, acetaminophen and ibuprofen can be dangerous so return bottle to a safe place and don't exceed the recommended dosage of acetaminophen or ibuprofen.**

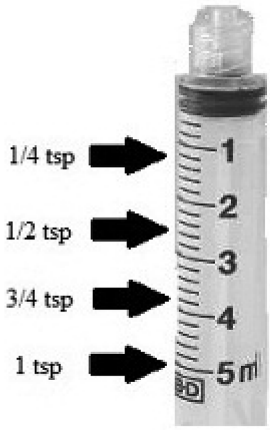
YOU NEED TO CALL OUR OFFICE DURING REGULAR OFFICE HOURS IF:

1. Your child seems very ill.
2. Fever continues for more than 24 hours and your child has not been examined in the office.
3. Fever of any degree if your child appears very ill and has not been examined in the office.

YOU NEED TO CALL AT ANY TIME IF:

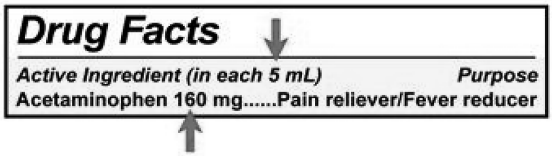
1. Your child is less than 3 months old and has a rectal temperature greater than 100.4 degrees F. and has not been seen by the doctor.
2. Fever of greater than 105 degrees F. and has not been seen by the doctor.
3. Your child is extremely irritable and cannot be consoled, regardless of the temperature.

Teaspoons (tsp)	Milliliters (mls)
¼ tsp	1.25 mls
½ tsp	2.5 mls
¾ tsp	3.75 mls
1 tsp	5 mls



Acetaminophen

Acetaminophen is available in many brands including Tylenol, Fever All, Pediacare, and Triaminic Fever Reducer. Do not use any combination products that contain cold and cough medicines with acetaminophen. Always check the strength of the medication on the back of the bottle. **Whether you are giving children's or infant's acetaminophen, the strength of the medication should be <u>160mg/5ml.</u>**



Acetaminophen can be given every 4 hours as needed for pain or fever. Do not give more than 5 doses in 24 hours. Children's dose is determined by weight, not age. Please contact your child's pediatrician if you have any questions before giving your child any medications.

Acetaminophen Dosing Chart

Weight (pounds)	Oral Suspension (160mg/5ml)	Tylenol Chewable Tablets (160mg tab) 6 Years and up	Adult Strength (325mg tab) 11 Years and up	Extra Strength (500mg tab) 12 years and up
6-11 lbs	1.25 mls	---	---	---
12-17 lbs	2.5 mls	---	---	---
18-23 lbs	3.75 mls	---	---	---
24-35 lbs	5 mls	1 tab	---	---
36-47 lbs	7.5 mls	1½ tabs	---	---
48-59 lbs	10 mls	2 tabs	---	---
60-71 lbs	12.5 mls	2 ½ tabs	---	---
72-95 lbs	15 mls	3 tabs	---	---
96+ lbs	---	4 tabs	2 tabs	---
125+ lbs	---	---	---	2 tabs

Ibuprofen

Ibuprofen is a powerful pain reliever, fever reducer and anti-inflammatory medication. Since it can cause abdominal pain, vomiting and occasional problems with urinary function, we prefer that it be used only for very high (>104 degrees) or persistent fever. We also use ibuprofen for athletic injuries, arthritic and muscular pains. Ibuprofen is relatively safe if used properly. When using ibuprofen, **whether children's or infant's, the strength should be 100mg/5ml. Do not use concentrated drops.**

Ibuprofen can be given every six hours as needed for fever or pain. Children's dose is determined by weight, not age. **However, do not use on children less than 15 pounds or less than 6 months of age. Do not use ibuprofen if your child has abdominal pain, vomiting or dehydration.**

Ibuprofen Dosing Chart

Weight (pounds)	Oral Suspension (100mg/5ml)	Junior Strength Tablets (100mg/ tablet) 6 Yeas and up	Adult Tablets (200mg/ Tablet) 12 Years and up
15-17 lbs	2.5 mls	---	---
18-23 lbs	3.75 mls	---	---
24-35 lbs	5 mls	---	---
36-47 lbs	7.5 mls	---	---
48-59 lbs	10 mls	2 tabs	---
60-71 lbs	12.5 mls	2 ½ tabs	---
72-95 lbs	15 mls	3 tabs	---
96 + lbs	---	4 tabs	2 tabs

UPPER RESPIRATORY INFECTIONS

Upper respiratory infections (common cold) are caused by viruses and usually last 7-14 days. There are well over 100 viruses that cause colds and children average up to 8 colds per year. Colds are spread from one person to another through air or by direct contact. They have a variety of symptoms including sneezing, runny nose, cough, mild sore throat, malaise (tiredness), loss of appetite and fever. If present, a fever usually occurs the first two days and is rarely over 102.5 degrees.

ANTIBIOTICS are not helpful for the resolution of cold symptoms. Nasal drainage from colds may range from clear to yellow to green in color and should go away in 7-10 days. Yellow or green mucus does not mean your child has a bacterial sinus infection.

TREATMENT

There is not a medication that will shorten the duration of a cold (make it go away). Therefore, treatment is aimed at helping the child feel better. It is best to avoid most medications if the child is not very ill. They usually do not work well and have potential side effects which might be worse than the cold itself. Plenty of fluids and rest, saline nose drops, suctioning infants' noses with a bulb syringe, using a cool mist vaporizer to loosen nasal secretions and elevating the head of the bed will help your child feel better. (Vaporizers should be cleaned every 3 days to prevent growth of mold. Follow manufacturers directions for cleaning). There are many cold preparations available.

ACETAMINOPHEN (Tylenol) may help the child feel better whether or not a fever is present. If a child is less than 3 months old and fever over 100.4 degrees is present, contact our office. DO NOT GIVE COLD PRODUCTS CONTAINING ACETAMINOPHEN. We do not recommend the use of aspirin due to the possibility the child may develop Reye's Syndrome.

We do not recommend the use of cold and cough medications for children under age 2. The most helpful measures are fluids, saline and suction for congested noses and humidification.

ANTIHISTAMINES will not cure a cold, but may produce a slight reduction in nasal secretions. They may cause drowsiness. Benadryl is the most commonly used antihistamine.

DECONGESTANTS may reduce nasal congestion, but they may also cause irritability and sleeplessness. Topical decongestants such as NeoSynephrine nose drops have a significant rebound effect (ultimately making nasal congestion worse) and are not routinely recommended.

EXPECTORANTS have no proven medical benefit and are not needed. But, guafenesin, the most common, is found in many cold preparations.

COUGH SUPPRESSANTS may be used in older children at night to minimize cough from colds. Common cough suppressants include: dextromethorphan (found in Robitussin or the DM in many cold preparations) or diphenhydramine (found in Benadryl). Cough suppressants are no longer approved by the FDA for children under 6 years old.

COMPLICATIONS:
Ear infections are the most common complication of colds and may be accompanied by prolonged fever (greater than 48 hours), extreme fussiness, difficulty with sleep or ear pain. Bacterial ear infections usually need to be treated with antibiotics and should be seen by the doctor.

CONJUNCTIVITIS (pink eye, cold in the eye) may occur as part of a cold. If the drainage is only minimal, the condition may be observed and not treated; however, if the drainage becomes very thick, occurs all day long (not just after sleep time) or persists longer than 5 days, antibiotic eye drops are usually needed.

BRONCHITIS is an infection of the bronchial tubes and is another complication of a cold. Cough is prominent and may be accompanied by wheezing or shortness of breath. Fever may also occur. Bronchitis can be either viral or bacterial and may require treatment by a physician.

PNEUMONIA is a rare complication of a cold. It is an infection in the lungs and is usually accompanied by a very high fever (104 degrees), difficulty with breathing and extreme lethargy (difficulty staying awake). Children are very ill when they have pneumonia, they do not merely have a deep cough. Pneumonia requires prompt treatment by a physician.

SORE THROATS may occur because of post nasal drip. If tonsils are enlarged or if other unusual symptoms develop, the sore throat may be the result of a bacterial infection known as “Strep”. If a child does have Strep Throat, the child would need to have the throat cultured and treated by a physician.

SINUS INFECTIONS sometimes occur after a cold and usually have prolonged nasal congestion (greater than 2 weeks), cough, or malaise (tiredness). A thick green runny nose is not necessarily an indication of a sinus infection. In fact, it is usually a part of the natural resolution of a cold. BECAUSE OF CURRENT ANTIBIOTIC RESISTANCE PATTERNS, COLDS SHOULD NOT BE TREATED WITH ANTIBIOTICS UNLESS THERE IS GREAT CERTAINTY THAT A SINUS INFECTION IS PRESENT.

SUMMARY:
Call our office when your child exhibits any of the following:

a. cold symptoms and the child feels very ill
b. ear pain
c. difficulty breathing or chest pain
d. temperature greater than 102 degrees that does not respond to acetaminophen or temperature that develops in the latter stages of a cold
e. cold symptoms that last longer than 7-14 days
f. symptoms of dehydration(decreased urination, concentrated urine, pale skin,weakness, dry lips and tongue, decreased drinking or decreased tearing)

CROUP

Croup is a contagious viral infection which attacks the vocal cords and is usually accompanied by cold symptoms. It is usually worse in the middle of the night and is more serious in young children less than 2-3 years old. A croupy cough sounds like a barking dog or seal. Croup may last as long as a week, but symptoms are often worse the first few nights. The swelling around the vocal cords produces the harsh, barky cough. The swelling may worsen and cause problems with breathing (stridor). Treatment is aimed at reducing the swelling:

1. Cool Air - either cool night air or with a cool mist vaporizer. Even standing in front of an open freezer for 5-10 minutes may help.
2. Moist Air - either with a cool mist vaporizer or a steamy bathroom (close the bathroom door, turn on the hot shower and steam up the room).
3. Cool Liquids

If your child is still having trouble breathing after 10 minutes in a steamy bathroom followed by 10 minutes of very cold air, proceed immediately to East Tennessee Children's Hospital Emergency Room.

VOMITING AND DIARRHEA
(ACUTE GASTROENTERITIS)

Vomiting and Diarrhea are common problems in infants and young children. These symptoms are usually caused by viruses and are usually self-limited if cared for appropriately, i.e. they do not need to be treated. Vomiting normally lasts 24-48 hours and diarrhea 1 to 2 weeks. However, if any of the following problems are also present, you should contact our office for further instructions.

1. Fever over 102 degrees F. which does not respond to acetaminophen or which reoccurs for more than 24 hours.
2. SEVERE abdominal (stomach) pain or cramps.
3. Pain other than in the abdomen.
4. Blood in the stools or vomitus.
5. Signs of dehydration: decreased urination (longer than 6-8 hours), concentrated urine, pale skin, weakness, dry lips and tongue, decreased drinking or decreased tearing.

If none of the above are present, FOLLOW THESE INSTRUCTIONS:

1. Nothing by mouth for 1-2 hours after the onset of vomiting or frequent diarrhea (more than 5 times a day). If significant vomiting persists call the office for further instructions.
2. Then give ONLY clear liquids (no solid food, no milk, no orange juice nor plain water) until vomiting has stopped for 4-6 hours. Begin in small amounts;one ounce every 15-20 minutes increasing the amount very slowly.

Here are some clear liquids to try:

For infants:

A. Pedialyte
Pedialyte popsicles
Ricelyte
Infalyte
Kao-lectrolyte
Breastfed infants may continue to nurse.

For children 4-6 months, in addition to above:

B. 7-Up	C. Broth	Pedialyte
Dr. Pepper	Popsicles	Pedialyte popsicles
Sprite	Jell-O	
Ginger Ale	Kool-Aid	
Coca-Cola	Apple Juice	
Gatorade	Weak Tea	

3. After 8-12 hours without vomiting and lessened diarrhea (less than 7 stools per day) begin the following:

D. Bananas	E. Dry baked or boiled potatoes
Rice or	Cottage Cheese
Rice Cereal	Boiled or poached eggs
Crackers	Yogurt
Applesauce	Dry cereal
Toast (dry)	Pasta

F. Baked or broiled fish, chicken or turkey
Lean baked or broiled red meat
Carrots
Milk or formula

4. Stools may remain small, green, poorly formed and with mucus for1 to 2 weeks. If they number less than 5 per 24 hours, you can continue to advance the diet.

VI.. COMMON CHILDHOOD INJURY REFERENCE

POISONING:

Poison Control: 1-800-222-1222

Call our office or poison Control immediately for instructions. Never induce vomiting unless you have been specifically instructed to do so. Vomiting can make the situation much worse with some poisons.

BURNS:

Apply cold water or ice immediately. If the area is extensive, we need to evaluate or if it is after hours, we recommend the Emergency Room at East Tennessee Children's Hospital. Smaller burns can be treated at home by cleansing with soap and water followed by an application of an ointment like Neosporin or Betadine. The burn should be covered with a clean, dry bandage. Do not purposely puncture blisters as this could lead to infection. Severe pain, excessive redness or pus could mean infection and we need to evaluate these burns in the office.

CUTS & SCRAPES:

Clean as soon as possible with soap and large amounts of water. Dry with a clean cloth and apply an ointment like neosporin or Betadine.

If the cut is still bleeding after cleansing, apply firm pressure. If the edges of the cut gape open or bleeding persists, stitches are probably necessary. Sutures must be done within 8 hours of the cut. We suture most lacerations in our offices, but after hours we refer our patients to the Emergency Room at East Tennessee Children's Hospital. Following a deep cut, if your child has not had a tetanus shot within the last five years, it should be given within 48 hours.

BUMPS, BRUISES AND BROKEN BONES:

Ice will reduce swelling and should be applied immediately. If the area is very large, very tender or results in the inability to move an arm, leg, finger or toes, we need to check for a fracture. If you suspect a broken bone, splint gently with a newspaper or board. We are able to evaluate fractures in our office, but after hours we recommend The Emergency Room at East Tennessee Children's Hospital.

HEAD INJURY:

Most head injuries require either phone consultation or examination. Any person receiving a blow to the head may have injury to the brain or small blood vessels which is not always evident on x-rays or exams immediately following the accident; therefore, it is important to observe your child closely during the 48 hours after a head injury and telephone us should any of the following signs of trouble develop.

1. Loss of consciousness, even if for only a short time.
2. Vomiting.
3. Double vision.
4. Persistent dizziness.
5. Severe headache, not relieved by Tylenol.
6. Excessive drowsiness.
7. An obvious depression in the skull.

POST-HEAD INJURY CARE: If none of the above have occurred, the child can be observed at home and may be allowed to sleep for up to two hours. Then the child should be awakened and checked by observing his or her balance during walking, understanding of commands (e.g., "John, go to the kitchen and get a spoon"), and general appearance.

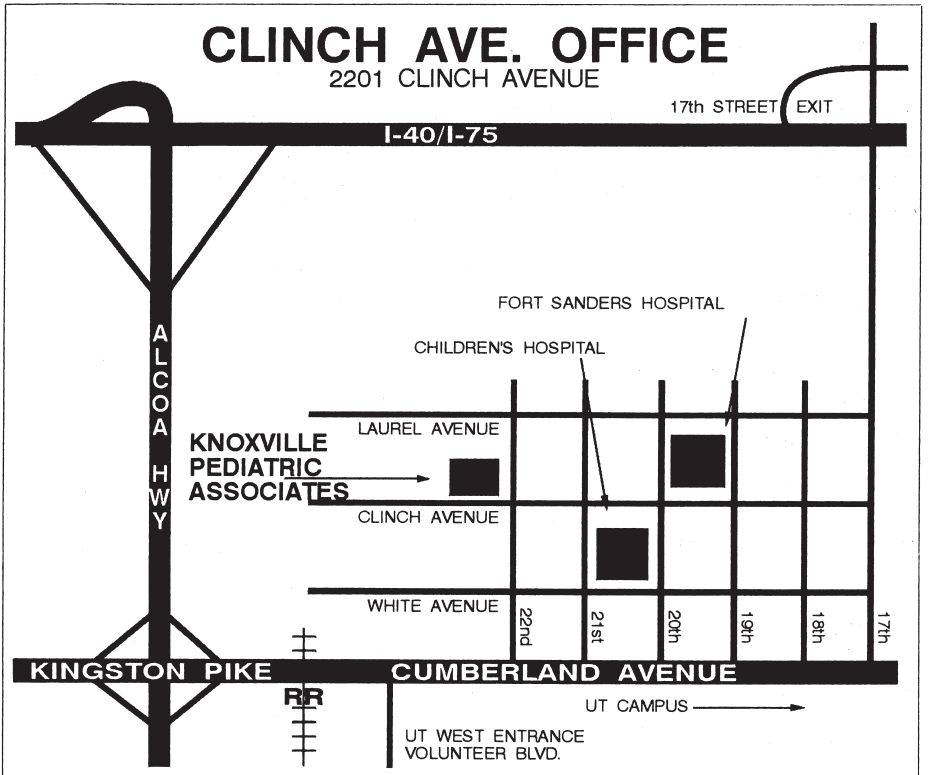
For an infant, observe to see that the child is alert, follows a brightly colored object with his or her eyes, and has normal movement of both sides of the body. Your child should continue to be wakened every two or three hours for twelve hours after the injury. It is not uncommon to have mild headaches for several days after a head injury. If you are uncertain of the child's status, call the office for further advice.

When your child has a head injury, be sure you have had all of the signs of danger explained to you and that all of your questions have been answered.

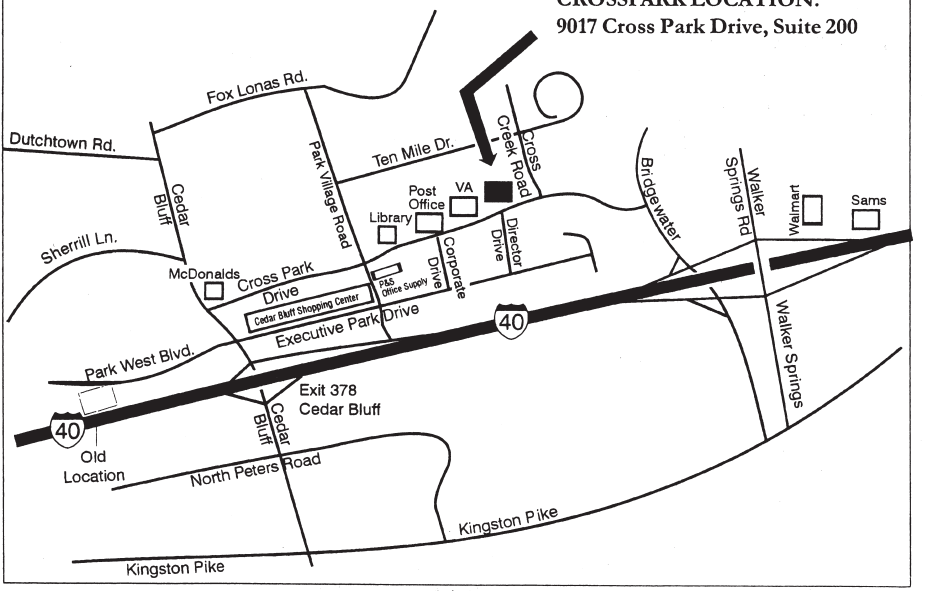
KNOXVILLE PEDIATRIC ASSOCIATES

CLINCH AVE. OFFICE

2201 CLINCH AVENUE



CROSSPARK LOCATION:
9017 Cross Park Drive, Suite 200



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