



Illnesses and Issues

A Parent's Guide

*Recognizing symptoms
and when to call your
child's doctor*

The Everett Clinic
For the whole you.

A Parent's Guide to
Common Illnesses & Issues

Recognizing symptoms and
when to call your child's doctor



PART 1 OF A 3-PART PARENTING SERIES

FOREWORD

This handbook has been prepared by the staff and physicians of The Everett Clinic. Its purpose is to offer description and treatment of common pediatric and adolescent health problems, provide tips on promoting positive parenting and help familiarize you with The Everett Clinic Family Medicine and Pediatric Departments' services.

We welcome any comments or suggestions on how we can better serve you. Our goal is to promote physical and emotional health in your child or adolescent. This handbook is designed to help you meet that goal.

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For more information on any of these topics, or other health-related issues, please visit www.everettclinic.com/healthwise.

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Acne

Acne occurs during the adolescent and young adult years. It can consist of blackheads, whiteheads (pimples), or red bumps on your face, neck, and shoulders.

Cause

- Acne is due to an overactivity and plugging of the oil glands. More than 90 percent of teenagers have some acne. The main cause of acne is increased levels of hormones during adolescence.
- Acne is not caused by sexual activity. It is not caused by dirt nor by not washing your face often enough. The tops of blackheads are black because of the chemical reaction of the oil plug with the air.

Home Care

There is no magic medicine at this time that will cure acne. However, good skin care can keep acne under control and at a mild level.

Basic treatment for all acne:

- **Soap:** Wash your skin twice a day and after exercise. The most important time to wash is bedtime. Use a mild soap such as Dove soap or a gentle acne wash.
- **Hair:** Shampoo your hair daily.
- **Avoid picking:** Picking stops acne from healing.

Treatment for whiteheads and blackheads:

Benzoyl peroxide 5% lotion or gel:

- This lotion helps to open pimples and unplug blackheads. It also kills bacteria. It is available without a prescription.
- Apply the lotion once a day at bedtime.
- An amount of lotion the size of a pea should be enough to cover most of your face. If your skin becomes red or peels, you are using too much of the medicine or applying it too often. Try using less of it or applying it less often. You may need to use this lotion for several years.

Treatment for red bumps:

Large red bumps mean the infection has spread beyond the oil gland. You may also need an antibiotic. They can only be prescribed by your doctor or nurse practitioner.

Common mistakes in treating acne:

- **Avoid scrubbing your skin.** Hard scrubbing of the skin is harmful because it irritates the openings of the oil glands and can cause them to be more tightly closed.
- **Avoid putting any oily or greasy substances on your face.** Oily and greasy substances make acne worse by blocking oil glands.
- **Don't stop your acne medicine too soon.** It takes 4-8 weeks to see a good response.

Call Your Health Care Provider During Office Hours if:

- The acne has not improved after you have treated it with benzoyl peroxide for two months.
- It looks infected (large, red, tender bumps).
- You have other concerns or questions.

Written by B.D. Schmitt, M.D., author of "Your Child's Health," Bantam Books. Copyright 2004 McKesson Health Solutions.

Asthma

What is asthma?

Asthma is a chronic disease of the tubes that carry air to the lungs. The inner lining of the airways become swollen (inflammation) and the muscles around the airways tighten (bronchospasm) narrowing the airways further. The severity of asthma varies over time, and patients may not always have symptoms. When asthma is controlled, your child should be able to do everything someone without asthma can do.

Symptoms of asthma include:

- Wheezing
- Coughing, especially at night
- Shortness of breath
- Tightness in the chest

If you are concerned your child may have asthma, talk to your health care provider.

Diagnosis

It can be challenging, especially in young children, to be certain that asthma is the diagnosis. After examining your child, your provider will need to ask you specific questions about your child's health. The information you give will help determine if your child has asthma. This information includes:

- Your child's symptoms, such as wheezing, coughing, and shortness of breath
- What triggers the symptoms or causes the symptoms to get worse
- Medications that were tried and if they helped
- Any family history of allergies or asthma

Once your child is old enough to cooperate, we can test your child's airway function, using a device called a spirometer which measures the amount of air blown out of the lungs over time. Your provider may also want to do another spirometry after giving asthma medication.

It is important to keep in mind that not all children with repeated episodes of wheezing have asthma.

Treatment

One goal of treatment is to minimize symptoms and allow children to participate in normal physical activities with minimum side effects. A second goal is to prevent ER visits and hospitalizations due to asthma attacks.

Asthma is different in every patient, and symptoms can change over time. Which asthma medication is best for your child is decided upon based on the severity and frequency of symptoms and your child's age. Children with asthma symptoms that occur only once in a while are often given medications for short periods only. Children with asthma whose symptoms occur more often need to take controller medications every day. Sometimes it is necessary to take several medications at the same time to control and prevent symptoms. Your provider may give your child several medications at first, to get the asthma symptoms under control, and then decrease the medications as needed.

Asthma medications are divided into 2 groups: quick-relief medications and controller medications.



Quick-Relief Medications

Quick-relief medications, or bronchodilators, are for short-term use to open up narrowed airways and help relieve the feeling of tightness in the chest, wheezing, and breathlessness. They can also be used to prevent exercise-induced asthma. The most common quick-relief medication is **albuterol**.

Controller Medications

Controller medications are used on a daily basis to control asthma and reduce the number of days that your child has symptoms. They are not used for relief of symptoms. Children with symptoms more than twice per week or who wake up more than twice per month should be on controller medications. These medications need to be taken every day, even if your child is feeling well.

Inhaled corticosteroids such as **flovent** and **pulmicort** are very effective, and, when used in the recommended doses, they are safe for most children.

Asthma Action Plan

It is helpful to have an asthma action plan written down so you can refer to it from time to time. Such a plan should contain information on daily medications your child takes as well as instructions on what to do for symptoms. Ask your provider to help you create an action plan for your child.

Exercise-Induced Asthma

Exercise can trigger symptoms in children with asthma. It can almost always be prevented with use of albuterol taken 15 minutes or more before exercise. If it occurs frequently, however, it may mean your child's asthma is not under control. Proper asthma control can make a great difference in the ability for a child to exercise normally.

Get a flu shot every fall!

Patients with asthma are at a much greater risk for complications when they are sick with influenza. Therefore, all patients and their household contacts are recommended to get immunized annually against influenza.

Additional Information:

American Academy of Pediatrics, www.aap.org

National Heart, Lung, and Blood Institute (NHLBI) Health Information Center, www.nhlbi.nih.gov

American Academy of Allergy, Asthma, and Immunology, www.aaaai.org

Asthma and Allergy Foundation of America, www.aafa.org

Adapted from information provided by the American Academy of Pediatrics.

Autism

What is autism?

Autism spectrum disorders are a group of biologically based neurodevelopmental disorders characterized by impairments in socialization, communication, and behavior. The spectrum includes children with Aspergers syndrome, PDD (pervasive developmental disorder), and autism. Some children have very minor difficulties with language or peer relations, while other children may be completely nonverbal and unable to attend regular school. Autism is not rare; it is estimated to affect between 1 in 150, and 1 in 500, children.

What causes autism?

Nobody understands the cause of autism. We know it is partly genetic. Many studies have looked for a possible connection between childhood immunizations and autism, but they have found no connection. Scientists are looking for other causes such as viral illnesses or exposure to possible toxins.

We do know that autism is not anyone's fault. It is not due to anything the child or parent did wrong.

How is autism diagnosed?

Autism is diagnosed by your doctor or a specialist in autism, over time, with the input of parents, other family members, teachers, and daycare providers. You will be asked questions about your child's development and behavior at every well check, starting with her very first visit. If you have concerns at other times, schedule a visit for further evaluation. Do not ever feel that your concerns are silly. Families of children with autism spectrum disorders are often referred to specialists for further evaluation.

Early symptoms and signs include:

- No babbling by 9 months
- No pointing or gestures by 12 months
- No single words by 15 months
- No two-word phrases by 24 months
- Poor social skills
- No pretend play by 18 months
- Any loss of language or social skills at any time

How is autism treated?

Treatment includes developmental services through the school district if your child is at least three years old, and the Early Intervention program for younger children. Parents also become very involved with therapy for their children. Ongoing support is provided by your pediatrician, family doctor, or nurse practitioner, and community agencies.

Where can I learn more about autism?

- Talk with your child's provider about your questions.
- The CDC's "Learn the Signs. Act Early" site (www.cdc.gov/ncbddd/autism/actearly)
- The CDC's Autism Information Center (www.cdc.gov/ncbddd/autism/index.htm)

Chicken Pox *Varicella*

The Illness:

Chicken pox is a viral infection of children caused by the varicella-zoster virus, and is associated with a fever and a rash. The rash starts as red bumps, but within 24 hours the bumps become water blisters, located anywhere on the body. The rash can be itchy, and the child may have body aches. The incubation period for chicken pox is 10-20 days, and a child is contagious until all the blisters have scabbed over.

The Immunization:

Chicken pox is uncommon now because most children have had the varicella vaccine. Two doses are recommended before kindergarten age. Some children who have had the vaccine will still get chicken pox, but it tends to be mild. There may be only a few bumps, and rather than turning into water blisters, the bumps develop a crust on top.

Even though chicken pox used to be common, it still can have serious consequences. Some children develop complications such as severe secondary skin infections, pneumonia, or brain inflammation. About a hundred people die every year from complications of chicken pox.

IT'S IMPORTANT TO HAVE YOUR CHILD VACCINATED!

Treatment:

Itching can be relieved by lukewarm oatmeal baths or anti-itch creams such as calamine. Oral antihistamines may help, especially at bedtime. Acetaminophen can be given for fever if needed. Make sure your child stays hydrated. Never give children aspirin.

Call our office if:

- your child's rash develops unusual redness, swelling, pain or drainage
- your child has extreme lethargy, dehydration, or severe stomachache
- you feel frightened or worried about your child's illness

Adapted from: Author: Anne A. Gershon, MD; Professor of Pediatrics; Director, Pediatric Infectious Diseases; Columbia University College of Physicians and Surgeons; New York, NY.

Colds and Flu

Colds and flu are illnesses caused by viruses. Most healthy children have six to nine viral infections each year. Each infection usually lasts from seven to fourteen days. This means your child may have a runny nose as much as one third of the year.

Symptoms of viral illness may include runny or congested nose, cough, sore throat, eye discharge, muscle aches, headache, vomiting and diarrhea. Your child may have a fever for the first few days. There are no cures for viral illnesses; antibiotics are **not** helpful. Any treatment measures recommended by your health care provider are directed at relieving individual bothersome symptoms.

Closely monitoring your child's symptoms may offer clues that complications are occurring: increasing irritability, lethargy, changes in sleep and feeding patterns (especially in infants and younger children). Other signs might include a cough that is becoming progressively worse, increased breathing rate, or complaints of ear pain.

Colds and flu are contagious illnesses; in fact most are contagious one or two days before any symptoms develop. Children should be kept home from school if their symptoms would not allow them to pay attention in class or would disturb other children in the classroom. Children usually restrict their own activity level and will go to bed if necessary. There is no need for the parent to restrict activity.

Over-the-counter cold and cough medicines (decongestants, antihistamines, expectorants, mucolytics, cough suppressants) are generally not helpful for children under 12 years old. Many studies have shown they do not help symptoms of cold and cough. Many of these medications have side effects which can interrupt your child's sleep or cause behavior changes. Hundreds of children visit the emergency department every year for overdoses, or unexpected side effects, of these medicines.

Therefore we recommend that you don't use these medicines for your child, especially under six years of age.

Colds usually get better by themselves within 7-14 days. Make sure your child is drinking plenty of fluids and getting rest. Acetaminophen or ibuprofen can be used if needed for comfort. Saline nose drops are safe, though they are rarely necessary.

Call Our Office Immediately if Your Child Develops:

- marked lethargy* or irritability.

Call Our Office During Regular Hours If Your Child Has:

- difficulty breathing
- worsening cough
- ear pain
- severe sore throat
- cold or flu symptoms and is an infant two months or younger
- no improvement over five days
- signs of dehydration**
- fever for more than three days

* *Lethargy is defined as listlessness; no eye contact; won't respond to voice or touch.*

** *Adequate hydration is defined as taking in and keeping down enough fluids to urinate at least three times a day.*

Normal Infant Crying

Not all infant crying is “colic.” Crying is normal for all babies. Young infants cry about two to three hours per day. Crying is a way for infants to communicate with their caregivers. Babies cry when they are hungry, tired, bored, in pain and to relieve stored-up tension.

Although crying is normal, it is important to LISTEN to your baby’s cry and ASSESS why she is crying. For example, it’s very common for babies to cry just before feeding time because they are hungry or when putting them down for a nap because they are tired. Another normal cry period for young babies seems to be the evening period. Ask yourself some questions when you hear your baby cry: Is she hungry? Does she just need to sleep? Could she have some trapped gas and need to burp? Is she sick? Has the day been very busy and the baby is over-stimulated? Attempt to answer these questions and meet the baby’s needs. Some babies will cry and you will not be able to comfort them. Before assuming it is “colic”, please consult with your health care provider to make sure the baby is healthy and growing properly.

Colic

Colic is fussiness and crying in an otherwise healthy, well-fed baby. About 10 percent of infants have colic. It usually begins in the first few weeks of life and disappears by the third month. Evening hours tend to be the worst time of day for colic symptoms.

The following suggestions can make colic easier to live with, but will not make the colic disappear. Colic will go away as the baby matures. No one really knows what causes colic. Remember that your baby is not sick and the colic will pass with time.

Some positions or things to try:

- Rock the child in a chair; walk briskly holding the baby
- White noise tapes, waterfall tapes and heartbeat tapes
- Snuggling, swaddling and cuddling; a “Snuggli”-type pack may be helpful
- Infant swing
- Car ride or stroller ride
- A calm, warm bath

If you are nursing your baby, don’t stop breast-feeding thinking some brand of artificial infant formula will solve the problem. Nursing mothers are often given advice from family and friends that they should avoid certain foods in their diets to “cure” colic in their infant. Rarely can foods you eat actually be implicated as the cause for your infant’s colic. In fact, most babies show no change in their crying patterns when mothers avoid such things as spicy foods, broccoli, cauliflower, onions, beans, garlic or milk.

If none of these measures quiets your baby and she has been fed in the last two hours, you may let your baby cry herself to sleep. On some days, this is the only answer for a fussy baby. Sometimes a crying baby can be frustrating. Remember, NEVER shake your baby.

If colic comes on suddenly, check the baby carefully from head to toe. There may be a thread wound around a toe or something poking the baby.

REMEMBER - Special bottles, formulas or medicines do not cure colic.

Hang In There!

Having a baby with colic is an extremely frustrating and exhausting experience. It does not mean that you are not wonderful, loving parents. Sometimes a baby just has to cry to release tension, nothing you do will prevent her from crying. Although it is very tough to listen to your own baby cry, it is not harmful for her. Most babies outgrow colic by three to four months of age and grow up to be happy, healthy children. Talk with other parents who have had a colicky baby.

Try to be patient — you will get through it!

Constipation

For Infants Less Than One Year Old:

It is not necessary to have a bowel movement every day. Some infants have bowel movements (BMs) only once every three to seven days, and they are perfectly normal.

Constipation can be a concern when the stool is very hard or when the baby experiences pain when passing stool. Babies less than six months of age commonly grunt, push, strain, draw up the legs and become flushed in the face during passage of BMs. These behaviors are normal and should remind us that it takes some time for the bowels and rectum to become coordinated.

Dietary changes are usually all that is necessary to treat your baby's constipation. For babies less than four months old, offer diluted prune or pear juice.

Call Our Office if:

- More than seven days have passed without a BM, and your baby is not breast-fed.
- Bright-red blood has been noticed on the stool more than twice.
- You are using suppositories or enemas to treat your baby's constipation.
- Your baby is in pain when having bowel movements.

For Toddlers and Children:

Constipation is a common and recurrent problem throughout the childhood years. Constipation is nearly always responsive to dietary changes. A diet high in fiber with plenty of fluids is very helpful in preventing constipation. Encourage your child to eat oatmeal, Cheerios, bran muffins, raisin bran, grapes, plums, prunes, prune juice, dried apricots, dried cranberries, raisins, dates, figs, popcorn, salads and whole grain foods. Almost all breads, crackers, waffles, bagels, muffins and chips come in a whole grain form, and those are the healthiest to buy. Cook with brown rice and whole grain pasta. Use whole grains such as barley and quinoa in soups. Avoid constipating foods such as white rice, apples, applesauce, bananas and too much dairy.

Encourage sitting on the toilet twice a day after meals and give them a special toy to play with. Try a warm bath which may help with relaxation. You can buy miralax (glycolax) over the counter. Put one capful of powder in eight ounces of water or juice and drink that once a day. This medication pulls more water into the colon and makes the stool softer and easier to pass. Occasionally there's a little diarrhea when you first start, but keep taking it anyway. The goal is at least one soft easy effortless painless quick stool per day.

Please Call Our Office If:

- Child has severe abdominal pain
- You are considering using enemas, laxatives or suppositories
- Child is soiling his pants
- Child is developing "toilet fears"

Croup

Description of Croupy Cough

- All children with croup have a tight, low-pitched “barking” cough.
- The voice is usually hoarse.

Description of Stridor (seen with severe croup)

- When your child breathes in, you hear a harsh, raspy, vibrating sound.
- Breathing is very difficult.
- Your child has severe croup (stridor only occurs with severe croup).
- Stridor is usually present only with crying or coughing.
- As the disease becomes worse, stridor also occurs when a child is sleeping or relaxed.

Cause

Croup is a viral infection of the vocal cords, voice box (larynx), and windpipe (trachea). It is usually part of a cold. Swelling of the vocal cords causes hoarseness.

Stridor occurs as the opening between the vocal cords becomes more narrow.

Expected Course

Croup usually lasts for 5 to 6 days and generally gets worse at night. During this time, it can change from mild to severe many times. The worse symptoms are seen in children under 3 years of age.

First Aid for Attacks of Stridor with Croup

If your child suddenly develops stridor or tight breathing, do the following:

1. **INHALATION OF MIST:** Moist air seems to work best to relax the vocal cords and break the stridor; try a humidifier or vaporizer, or take the child out in the cold night air.
OR
2. **THE FOGGY BATHROOM:** Have a hot shower running with the bathroom door closed. Once the room is all fogged up, take him in there for at least ten minutes. Try to help your child not be afraid by cuddling or reading a story.
3. **RESULTS OF FIRST AID:** Most children settle down with the above treatments and then sleep peacefully through the night. If your child continues to have stridor or difficulty breathing, call your child’s physician IMMEDIATELY. If your child turns blue, passes out, or stops breathing, call 9-1-1.
4. Do not give your child cold medicines and/or cough syrups, including those given in a nebulizer or rubbed on the chest.



Home Care for a Croupy Cough without Stridor

1. **HUMIDIFIER:** Dry air usually makes coughs worse. Keep the child's bedroom humidified. Use a cool mist humidifier if you have one. Run it 24 hours a day.
2. **EXPOSURE TO OUTSIDE AIR:** Cool air often helps shrink swollen mucus membranes and helps with the symptoms of croup. Bundle your child warmly and go outside for 20 minutes. This can often reduce the child's stridor and cough.
3. **THERE ARE NO COUGH MEDICINES that help with croup or any other cough.**
4. **CLOSE OBSERVATION:** While your child is croupy, sleep nearby so you can hear her.
5. **CONTAGIOUSNESS:** The viruses that cause croup are quite contagious until the fever is gone or at least during the first 3 days of illness. Since spread of this infection can't be prevented, your child can return to school or child care once he feels better.

Call Your Child's Health Care Provider Immediately If:

- Breathing becomes difficult.
- Your child starts drooling or spitting, or starts having great difficulty swallowing.
- The warm mist fails to clear up the stridor in 20 minutes.
- Your child starts acting very sick.

Call Your Child's Health Care Provider within 24 Hours If:

- The attacks of stridor occur more than three times.
- A fever lasts more than 3 days.
- Croup lasts more than 10 days.
- You have other concerns or questions.

Diaper Rash

What is a diaper rash?

A diaper rash is any rash on the skin area covered by a diaper. Almost every child gets diaper rashes. Most of them are due to prolonged contact with moisture, bacteria, and ammonia. Bouts of diarrhea cause rashes in most children.

How long will it last?

With proper treatment these rashes are usually better in 3 days. If the rash does not improve with treatment, then your child probably has a yeast infection (Candida). If your child has a yeast infection, then the rash becomes bright red and raw, covers a large area, and is surrounded by red dots.

How can I take care of my child?

- **CHANGE DIAPERS FREQUENTLY:** The key to successful treatment is keeping the area dry and clean so it can heal itself. Check the diapers about every hour or as often as possible, and if they are wet or soiled, change them immediately. Make sure that your baby's bottom is completely dry before closing up the fresh diaper.
- **INCREASE AIR EXPOSURE:** Leave your baby's bottom exposed to the air as much as possible each day.
- **CREAMS AND OINTMENTS:** Most babies don't need any diaper cream. However, you can apply an ointment to protect the skin after you clean the skin when changing the diaper. A barrier ointment, such as Vaseline, A&D Ointment or Desitin, is also likely to help whenever your child has diarrhea.
- **YEAST INFECTIONS:** If the rash is bright red or does not start getting better after 3 days of warm water cleaning and air exposure, your child may have a yeast infection. Apply an over-the-counter medication such as clotrimazole cream (such as Lotrimin or Mycelex) or other anti-fungal ointment (such as Monistat) four times a day.

When should I call my child's health care provider?

Call IMMEDIATELY if:

- The rash looks infected (pimples, blisters, boils, sores).
- Your child starts acting very sick.

Call within 24 hours if:

- The rash isn't much better in 3 days.
- The diaper rash becomes bright red or raw.
- You have other concerns or questions.

Diarrhea

Diarrhea is the sudden increase in the frequency and looseness of bowel movements (BMs). The best indicator of the severity of the diarrhea is its frequency.

The main complication of diarrhea is dehydration from the loss of too much body fluid. Symptoms of dehydration are a dry mouth, the absence of tears, infrequent urination, and a darker, concentrated urine. The main goal of diarrhea treatment is to prevent dehydration.

Cause

Diarrhea is usually caused by a viral infection of the lining of the intestines (gastroenteritis). Sometimes it is caused by bacteria or parasites. Occasionally a food allergy or drinking too much fruit juice may cause diarrhea. If your child has just one or two loose bowel movements, the cause is probably something your child ate.

Expected Course

Diarrhea, caused by a virus, usually lasts several days to two weeks regardless of treatment. The main goal of treatment is to prevent dehydration. Your child needs to drink enough fluids to replace the fluids lost in the diarrhea. Don't expect a quick return to solid bowel movements. In fact, following a viral infection, it can take up to two months for stools to become normal.

Home Care: Diet

IF YOUR CHILD IS VOMITING, THESE GUIDELINES MAY NOT BE SUFFICIENT. PLEASE REFER TO THE ARTICLE ABOUT VOMITING ON PAGE 40.

FORMULA-FED INFANTS (less than one year old and no evidence of dehydration)

- Continue to feed your child the full-strength formula or his usual diet (unless something seems to make it worse) without any changes to it.
- **Glucose-electrolyte solutions.**

If your child is not taking enough regular formula or his usual diet to maintain hydration, you can supplement with Pedialyte for the first 24 hours. Give as much liquid as your baby wants. Diarrhea makes children thirsty, and your job is to satisfy that thirst and prevent dehydration. Never restrict fluids when your child has diarrhea.

BREAST FED INFANTS (less than one year old and no evidence of dehydration)

- **Definition/special considerations**

No matter how they look, the bowel movements of a breast-fed infant must be considered normal unless they contain mucus or blood or develop a bad odor.

The frequency of bowel movements is also not much help in deciding whether your breast-fed infant has diarrhea. During the first two or three months of life, the breast-fed baby may normally have one stool after each feeding. However, if your baby's bowel movements abruptly increase in number, your baby probably has diarrhea. Other clues are poor eating, acting sick, and a fever.

- **Diet**

If your breast-fed baby has diarrhea, treatment is straightforward. Continue breast-feeding but at more frequent intervals. Don't stop breast-feeding your baby because your baby has diarrhea. For severe (watery and frequent) diarrhea, offer Pedialyte between breast-feedings for six to twenty-four hours only if your baby is urinating less frequently than normal.



Home Care: Other Aspects

1. Prevention

Diarrhea is very contagious. Always wash your hands after changing diapers or using the toilet. This is crucial for keeping everyone in the family from getting diarrhea.

2. Diaper rash from diarrhea

The skin near your baby's bottom can become irritated by the diarrhea. Wash the area near the bottom after each bowel movement and then protect it with a thick layer of petroleum jelly or other ointment.

3. Vomiting and diarrhea

If your child has vomited more than twice, follow the recommended treatment for vomiting instead of this treatment for diarrhea until your child has gone eight hours without vomiting.

4. Do not give any over-the-counter diarrhea medications.

Call Your Health Care Provider If:






- There are signs of dehydration (no urine in more than 8 hours, very dry mouth, no tears).
- Any blood appears in the diarrhea.
- Your child vomits the clear fluids three or more times.
- Your child starts acting very sick.
- A fever lasts more than three days.
- Mild diarrhea lasts more than two weeks.

Drug Doses for Over-the-Counter Medications

Acetaminophen & Ibuprofen Dosing Chart

Companies are changing the concentration of acetaminophen medication for infants. There are new dosing directions for these products. Confirm which product you have before measuring the dose to ensure you are using the correct amount. ALWAYS measure with the dosing device provided with the product.

Dosing of acetaminophen and ibuprofen is by weight. Age ranges are given for general guidance only.

WEIGHT <i>AGE</i>	8-12 lbs. <i>1-3 mos.</i>	12-17 lbs. <i>4-11 mos.</i>	18-23 lbs. <i>12-23 mos.</i>	24-35 lbs. <i>2-3 yrs</i>	36-47 lbs. <i>4-5 yrs</i>	48-59 lbs. <i>6-11 yrs</i>
Acetaminophen Infant Drops 80mg/0.8mL 	0.4mL (40mg)	0.8mL (80mg)	1.2mL (120mg)	1.6mL (160mg)	—	—
Acetaminophen Infant Solution 160mg/5mL 	1.25mL (40mg)	2.5mL (80mg)	3.75mL (120mg)	5mL (160mg)	7.5mL (240mg)	10mL (320mg)
Acetaminophen Suspension/ Solution  160mg/5mL	—	2.5mL (80mg)	3.75mL (120mg)	5mL (160mg)	7.5mL (240mg)	10mL (320mg)
Ibuprofen Infant Drops 50mg/1.25mL 	—	1.25mL (50mg)	1.875mL (75mg)	—	—	—
Ibuprofen Children's Solution  100mg/5mL	—	—	3.75mL (75mg)	5mL (100mg)	7.5mL (150mg)	10mL (200mg)

Acetaminophen may be given every 4 - 6 hours, not more than 5 times in 24 hours.

Ibuprofen may be given every 6 - 8 hours, usually no more than 3 times in 24 hours.

* Please consult your child's health care provider before administering this medication to infants six months of age or younger.

** DO NOT EXCEED 5 DOSES IN 24 HOURS.

What is Otitis Media?

Otitis Media means “inflammation of the middle ear.” The inflammation occurs as a result of a middle ear infection. It can occur in one or both ears.

Otitis Media is very common in young children but rare in adults. It usually occurs in the fall, winter and early spring months.

What are the Symptoms of Otitis Media?

The most prominent symptoms are a feeling of pressure or blockage in the ears and persistent ear pain. Children may tug on their ears, perhaps as a reaction to the discomfort or pain. Other symptoms may include fever, nausea and vomiting.

Hearing can also be somewhat muffled. This happens because the fluid in the middle ear prevents the eardrum from functioning as it should. The result is temporary hearing loss. Once the fluid drains, full hearing is restored.

What is the Treatment for Otitis Media?

80% of children with otitis media get better without antibiotics. Antibiotics are often prescribed for babies or children with fever, vomiting or a history of frequent ear infections.

Regardless of whether antibiotics are prescribed, treatment to reduce pain is helpful. In many instances, acetaminophen or ibuprofen will provide good pain relief. Home remedies such as applying warm compresses to the outer ear may be helpful.

How Can I Help Prevent Otitis Media?

- **Protect your child from second-hand tobacco smoke.** Children exposed to tobacco smoke have an increased risk of ear infections.
- **Reduce your child’s exposure to colds during the first year of life.** Most ear infections start with a cold. Try to delay the use of large day care centers during the first year by using a sitter in your home or a small home-based day care.
- **Breast-feed your baby during the first six to twelve months of life.** Antibodies in breast milk reduce the rate of ear infections.
- **Avoid bottle propping.** If you bottle feed, hold your baby at a 45° angle. Feeding in the horizontal position can cause formula and other fluids to obstruct the eustachian tube. Weaning your baby from a bottle between nine and twelve months of age will help stop this problem.

Eczema

Eczema is the condition of having dry skin, sometimes allergic, always itchy. It can involve just the elbows and knees, or it can involve the whole body. It comes and goes, gets better and worse, but tends to be chronic.

The cause:

Eczema is often inherited, and tends to occur in children and families with asthma, hay fever, and other allergies. Sometimes food allergies contribute to eczema, especially in infants.

Treatment:

Eczema is very treatable but takes patience and persistence to gain good control.

Bathing:

Dryness of the skin is the main problem. Since hot water and soap both tend to take the natural oils out of our skin, bathing habits are extremely important in controlling eczema.

For infants and small children, a bath every day is fine, using warm rather than hot water. It's best to use no soap at all. Things that get on babies' skin such as milk, sweat and saliva, all wash off with water. A shampoo once a week is plenty, though getting your child's hair wet with water at every bath is fine. It's best not to let your child sit in the shampoo rinse water. Transition your child to showers as soon as she's ready.

Adolescents generally shower every day, but should use warm water rather than hot. A gentle soap such as Dove can be used, in the skin fold areas only - armpits, neck, and groin. No soap is needed on the arms, legs, stomach or back. Teenagers generally need to shampoo their hair every day.

Moisturizers:

Immediately after towel-drying, while you're still in steamy bathroom, use a generous amount of unfragranced, uncolored moisturizer. The thicker and greasier, the better. You can try Vaseline, Aquafor, Eucerin, Lubriderm, Nivea, Keri, Curel, or baby oil. Use a lot and give it several minutes to soak in. Repeat moisturizers 3-4 times a day as needed to dry areas.

Medications:

Steroid creams can be useful in treating eczema. You can buy 1% hydrocortisone cream over-the-counter, and use it up to four times daily on the dry spots if needed. It is safe anywhere on the body, and even for babies. Stronger steroid creams are available only by prescription.

Antihistamines can be helpful to decrease the itching, and help prevent scratching, especially at night-time. You can give your child generic Benadryl, loratadine, or cetirizine, or other anti-itch medications can be prescribed if needed. Dress your child lightly to keep her cool and less itchy.

Call our office if:

- Your child's eczema appears crusty or inflamed or infected
- Your child's rash is not improving after two weeks of above treatment
- You have other concerns about your child's skin

Fever

What is a Fever?

Your child probably has a fever if her temperature is above 100°F. It doesn't matter where you take the temperature, and you never need to take a rectal temperature. Fever is just a sign of illness. Fevers are not dangerous. They do not cause brain damage. A small percentage of children have febrile seizures, but even then neither the fever nor the seizure causes damage to the child.

The fever is just a clue that your child is sick. Teething does not generally cause fevers above 100°F. Fevers generally last up to four days.

The exact level of fever is not important. What is important is the comfort of your child. We want her to be drinking well, urinating at least twice a day, and having alert periods throughout the day.

What Can You Do?

IF SHE HAS A FEVER AND IS UNCOMFORTABLE, DRESS HER LIGHTLY. Do not bundle her up. You can wipe her forehead or neck with a lukewarm washcloth. If your child smiles, plays and drinks well, you do not need to worry about the fever. If your child is sleeping, don't wake her up to give her medication. If the fever is high enough to need medication, she will awaken. If she gets chilled, then wrap her up until she feels comfortable.

YOU CAN GIVE HER ACETAMINOPHEN OR IBUPROFEN FOR COMFORT. Be sure to measure infant drops with the dropper on the bottle. Do not use a syringe or anything else to measure the dose of infant drops. Do not give a child aspirin unless you've been told to by your doctor. You do not need to take her temperature after giving the medicine. It does not matter how much her temperature comes down; what matters is that she seems more comfortable.

TAKING YOUR CHILD'S TEMPERATURE ONCE A DAY WHILE SHE'S SICK IS PLENTY. That way you'll know when the fever is gone.

ENCOURAGE EXTRA FLUIDS. The body loses fluids during fevers because of sweating. Encourage your child to drink extra fluids, but do not force her to drink.

DRESS YOUR CHILD IN LIGHT CLOTHING. Clothing should be kept to a minimum because most heat is lost through the skin. Do not bundle up your child. During the time your child feels cold or is shivering (the chills), give him a light blanket.

Call our office **IMMEDIATELY** if:

- Your child is less than two months old.
- The fever is over 105°F.
- Your child cries if you touch him or move him.
- Your child's neck is stiff.
- Any purple spots are present on the skin.
- Breathing is difficult and is not better after clearing the nose.
- Your child is unable to swallow anything and is drooling saliva.
- Your child looks or acts very sick (if possible, check your child's appearance one hour after he has taken acetaminophen).

Call within 24 hours if:

- The fever is 104° to 105°F, especially if your child is less than two years old.
- Burning or pain occurs with urination.

Call during regular office hours if:

- Your child has had a fever for more than 72 hours.
- The fever went away for more than 24 hours and then returned.
- Your child has a history of febrile seizures.
- You have other questions or concerns.

Written by B.D. Schmitt, M.D., author of "Your Child's Health," Bantam Books. Copyright 2004 McKesson Health Solutions.

Fever: Myths and Facts

Misconceptions about the dangers of fever are commonplace. Unwarranted fears about harmful side effects from fever cause lost sleep and unnecessary stress for many parents. Let the following facts help you put fever into perspective:

MYTH: All fevers are bad for children.

FACT: Fevers turn on the body's immune system. Fevers are one of the body's protective mechanisms. Most fevers are good for children and help the body fight infection.

MYTH: Fevers cause brain damage or fevers over 104°F are dangerous.

FACT: Fevers with infections don't cause brain damage. Only body temperatures over 108°F can cause brain damage. The body temperature goes this high only with high environmental temperatures (for example, if a child is confined in a closed car in hot weather).

MYTH: Anyone can have a febrile seizure (seizure triggered by fever).

FACT: Only 4% of children have a febrile seizures.

MYTH: Febrile seizures are harmful.

FACT: Febrile seizures are scary to watch, but they usually stop within 5 minutes. They cause no permanent harm.

MYTH: All fevers need to be treated with fever medicine.

FACT: Fevers need to be treated only if they cause discomfort. Usually that means fevers over 102°F or 103°F.

MYTH: With treatment, fevers should come down to normal.

FACT: With treatment, fevers usually come down 2° or 3°F.

MYTH: If the fever doesn't come down (if you can't "break the fever"), the cause is serious.

FACT: Fevers that don't respond to fever medicine can be caused by viruses or bacteria. Whether the medicine works or not doesn't relate to the seriousness of the infection.

MYTH: If the fever is high, the cause is serious.

FACT: If the fever is high, the cause may or may not be serious. If your child looks very sick, the cause is more likely to be serious.

MYTH: The exact number of the temperature is very important.

FACT: How your child looks is what's important, not the exact temperature.

Fifth Disease *erythema infectiosum*

What is Fifth disease?

Fifth disease was so named because it was the fifth pink-red infectious rash to be described by doctors.

With Fifth disease:

- Your child has a bright red or rosy rash on both cheeks for 1 to 3 days (“slapped cheek” appearance).
- The rash on the cheeks is followed by a pink lacelike or netlike rash on the arms and legs (mainly on the thighs and upper arms).
- The “lacy” rash may come and go several times for weeks.
- Your child has a low-grade fever or no fever at all.

What is the cause?

Fifth disease is caused by a virus called human parvovirus B19.

How long does it last?

This is a very mild disease with either no symptoms or a slight runny nose and sore throat. The lacelike rash may come and go for weeks, especially after warm baths, exercise, and sun exposure.

How can I take care of my child?

No treatment is necessary. This distinctive rash is harmless and causes no symptoms that need treatment.

Is there a risk to pregnant women?

Yes. If a pregnant woman is exposed to a child with Fifth disease, she should see her obstetrician. An antibody test will be done to see if the mother already had the disease and is therefore protected.

When is it most contagious?

Children will come down with the rash 10 to 14 days after they have been exposed to the virus. The disease is contagious during the week before the rash begins. Therefore, exposed children should try to avoid contact with pregnant women, but that can be difficult. Once a child has the bright red or lacy rash, he is no longer considered contagious and does not need to stay home from day care or school.

When should I call my child’s health care provider?

Call during office hours if:

- Your child develops a fever for more than three days.
- You have other concerns or questions.

Hand, Foot and Mouth Disease

Cause

Hand, foot, and mouth disease is caused by the Coxsackie A-16 virus. It has no relationship to hoof and mouth disease of cattle.

Symptoms

- Small, painful ulcers in the mouth
- Small water blisters or red spots located on the palms and soles, and on the webs between the fingers and toes
- Five or fewer blisters per hand or foot
- Sometimes, small blisters or red spots on the buttocks
- Low-grade fever between 100 and 102 degrees F (37.8 and 38.9 degrees C)
- Mainly occurs in children age six months to four years.

Expected Course

The fever and discomfort are usually gone by day three or four. The mouth ulcers resolve in seven days, but the rash on the hands and feet can last 10 days. The only complication seen with any frequency is dehydration from refusing fluids.

Home Care

- 1. ANTACID SOLUTION FOR PAIN RELIEF:** For very young children, put 1/2 teaspoon antacid solution in the front of the mouth four times a day after meals. Children over age four can use one teaspoon of an antacid solution as a mouthwash after meals.
- 2. DIET:** Offer a soft diet. Use a cup instead of a bottle to give fluids to very young children. Cold drinks, milkshakes and Popsicles are good choices. Avoid citrus, salty, or spicy foods.
- 3. MEDICATION:** Give acetaminophen or ibuprofen for severe mouth pain or fever.
- 4. CONTAGIOUSNESS:** Hand, foot, and mouth disease is quite contagious. Usually some of your child's playmates will develop it at about the same time. The incubation period after contact is three to six days. Because the spread of infection is extremely difficult to prevent and the condition is harmless, these children do not need to be isolated. They can return to day care or school when the fever returns to normal. While most children are contagious from two days before to two days after the rash, avoiding other children is unnecessary.

Call your child's physician immediately if:

- Your child has not urinated for more than twelve hours.
- Your child starts acting very sick.

Call your child's physician during office hours if:

- The fever lasts more than three days.
- You have other concerns or questions.

Head Injury

What is a head injury?

Every child sooner or later strikes his head. Falls are especially common when your child is learning to walk. Most bruises occur on the forehead. Sometimes black eyes appear 3 days later because the bruising spreads downward by gravity. Your child may also have a cut, scrape, bruise, or swelling on the scalp. Those of most concern result in unconsciousness, confusion or amnesia.

How long does it last?

Most head injuries are simply a scalp injury. Big lumps can occur with minor injuries because the blood supply to the scalp is so plentiful. For the same reason small cuts on the head may bleed a lot. Only 1% to 2% of injured children get a skull fracture. Usually there are no associated symptoms except for a headache at the site where the head was hit. Your child has not had a concussion unless there is temporary unconsciousness, confusion, and amnesia.

How can I take care of my child?

- **WOUND CARE:** If there is a scrape, wash it off with soap and water. Then apply pressure with a clean cloth for 10 minutes to stop any bleeding. For swelling, apply ice for 20 minutes.
- **REST:** Encourage your child to lie down and rest until all symptoms have cleared (or at least 2 hours). Your child can be allowed to sleep; trying to keep your child awake continuously is unnecessary. Just have him sleep near by so you can periodically check on him.
- **DIET:** Only give clear fluids until your child has gone 2 hours without vomiting. (Vomiting is common after head injuries.)
- **SPECIAL PRECAUTIONS AND AWAKENING:** Although your child is probably fine, close observation for 1-2 days will ensure that no serious complication is missed.
Awaken your child twice during the night. Do this once at your bedtime and once 4 hours later. Awakening him every hour is unnecessary and next to impossible. Arouse him until he is walking and talking normally.

When should I call my child's health care provider?

Call **IMMEDIATELY** if:

- Your child loses consciousness.
- The skin is split open and might need stitches.
- The headache becomes severe.
- Vomiting occurs 3 or more times.
- Your child's vision becomes blurred or double.
- Your child becomes difficult to awaken or confused.
- Walking or talking becomes difficult.
- Your child's neurological condition worsens in any other way.

Head Lice: Prevention and Treatment

Facts of Lice

- Head lice do not transmit disease.
- Head lice need human blood to survive.
- Head lice prefer clean hair - but will get on anyone...young, old, rich, poor, clean, dirty.
- Head lice don't fly, hop, or jump - they crawl.
- Head lice do not live on pets or other animals.

Lice Words Defined:

- A louse = one lice bug.
- Lice = more than one louse.
- Nit = a louse egg.
- Nymph = a young louse.

Life of a Louse

Lice lay their eggs, called nits, onto the hair close to the head. They use a glue that firmly holds the nits or eggs onto the hair. The nits or eggs can be clear, white, yellow, brown, or gray. It takes about a week for the nits or eggs to hatch. Head lice are clear in color when they hatch.

It takes about seven to ten days for a newborn louse to become an adult. At this point she can begin laying eggs. One louse can lay six to eight eggs or nits a day for nine to ten days.

Adult head lice are reddish-brown in color. Lice have six legs with claws to help hold onto the hair. Adult lice are about the size of a sesame seed.

The total life span of a louse beginning with the egg or nit is about 25 to 30 days.

How Lice Spread

- Lice spread through head to head contact.
- Lice may spread when personal items are shared.

How to Prevent Head Lice Infestations

- Don't share items that have been in close contact with the head. A louse might be hiding in hats, coats, combs, brushes, barrettes, helmets, or pillows, especially if they were recently used.

Checking for Lice

- Check your child's head for lice if your child is scratching his head more than usual.
- Lice and lice eggs or nits are very small, so use a bright light.

Here are a few pointers to help you identify nits:

- Nits are hard to remove from your hair and are glued to the hairshaft at an angle.
- Nits feel like little grains of sand stuck to the hair, so you may feel them even if you can't see them!
- Dandruff can be flicked away easily with your finger. NITS CAN'T!
- Nits are tiny and can be clear, white, yellowish, brown or sometimes gray. Dandruff is usually larger and white. Nits may vary in size, but are always the same oval shape.
- Nits are usually laid close (1/8"-3/16") to the scalp and most often found around the ears and along the nape back of the neck. However, eggs found further away from the scalp are not always dead or empty. They still might hatch.



If You Find Nits or Lice

You can buy pediculocide (lice medicine) over-the-counter. Pyrethrin and permethrin are available to treat head lice, under brand names Rid, Nix and others. DSHS will usually pay for these treatments. You'll need a metal fine-tooth comb. Follow the directions on the package carefully. You may repeat this treatment once if lice are not gone after 1-2 weeks, but do not use more than that.

Combing:

Head lice and nits may be removed by combing with a special lice comb every day for three weeks.

What about nit picking?

When you see a nit that won't come off the hair with a comb, use your fingernails to slide the nits off the hair. That is called "nit picking". Nit picking is part of the combing process.

Cleaning Household Items to Get Rid of Lice

Cleaning clothes, the house and household items is not as important as you might think. Lice cannot live more than two days off of a head. There is no need to clean every nook and cranny. If lice return, it is usually because a louse or nit was missed during combing, or because your child was exposed again.

Pets cannot get head lice. Don't use lice pesticides on your pets.

Suggested household cleaning:

Clean items used by people with lice during the two days before you began lice treatment.

- Wash sheets, pillow cases, towels, and clothing. Use hot water (130° degrees) and the "hot" dryer setting for 30 minutes.
- Things that can't be washed can be sealed in a plastic bag for two weeks or dry cleaned: coats, hats, helmets, scarves, stuffed animals, pillows, and comforters.
- Wash brushes, combs, barrettes and other hair holders thoroughly with hot (130° degree) soapy water.
- Vacuum the floor, furniture, car seats and headrests used by the person with lice.

People You Can Contact for Additional Help

- Your child's school nurse
- Your health care provider
- **Snohomish Health District:** 425-339-5259
- **National Pediculosis Association:** www.headlice.org/kids
- **Washington State Department of Health:** www.doh.wa.gov/publicat/publications
- **U.S. Environmental Protection Agency, Integrated Pest Management for Schools:** A How-To-Manual. Chapter II: IPM for Head Lice in Schools: www.epa.gov (on site "search" type in: IPM for schools)
- **U.S. Food and Drug Administration:** www.fda.gov (on site "search", type in: head lice)
- Call our office for a "Lice Aren't Nice" booklet with all the information you'll need.

The purpose of this chapter is to give you the most current information about head lice. Descriptions of brand name products are for identification only and do not constitute endorsement by the Snohomish Health District, even when the advantages of one product over another is described. Details are provided for your information only.

Hives

What are hives?

Hives are a very itchy rash, sometimes caused by an allergic reaction. Hives look like raised pink spots with pale centers on the skin. The spots range from 1/2 inch to several inches wide. The spots may be different shapes. The spots rapidly and repeatedly change in location, size, and shape.

What is the cause?

Widespread hives can be an allergic reaction to a food, medicine, insect bite, or from a viral infection. Often the cause is not found. Hives are not contagious.

How long do they last?

More than 10% of children get hives. Most children who develop hives have them only once. The hives come and go for 3 or 4 days and then mysteriously disappear.

How can I take care of my child?

If your child feels fine, you don't need to do anything.

Antihistamine medicine

The best drug for bothersome hives is an antihistamine. An antihistamine won't cure the hives, but it may reduce their number and relieve itching. Generic Benadryl, loratadine, and cetirizine are available without a prescription.

Itching

Apply a cool cloth to relieve itching. Dress lightly.

When should I call my child's health care provider?

Call IMMEDIATELY if:

- Breathing or swallowing becomes difficult.
- Your child starts acting very sick.

Call during office hours if:

- The hives last more than 1 week.
- You have other concerns or questions.

Nosebleeds *epistaxis*

Nosebleeds (epistaxis) are very common throughout childhood. They are usually caused by dryness of the nasal lining plus the normal rubbing and picking that all children do when the nose becomes blocked. Vigorous nose blowing can also cause bleeding. All of these behaviors are increased in children with nasal allergies.

Home Care

Lean Forward and Spit Out Any Blood. Have your child sit up and lean forward so he does not have to swallow the blood. Have a basin available so he can spit out any blood that drains into his throat. Blow his nose free of any large clots that might interfere with applying pressure.

Squeeze the Soft Part of the Nose. Tightly pinch the soft parts of the nose against the center wall for about 10 minutes. If the bleeding continues, you may not be pressing on the right spot.

Swallowed blood is irritating to the stomach. Don't be surprised if it is vomited up.

Prevention

- A small amount of petroleum jelly applied two to four times each day inside the nose is often helpful for relieving dryness and irritation.
- Increase the humidity in the room at night by using a humidifier.

Call our office during regular hours if:

- Nosebleeds occur daily even after petroleum jelly and humidification are used
- Bleeding has not stopped after one hour of pressure
- It is a large volume of blood, greater than one ounce
- You have other concerns or questions

Obesity

Obesity has become a serious health problem in America. About two thirds of adults are obese or overweight, and children have higher percentages of obesity than ever before.

How is obesity defined?

We measure your child's height and weight at every well check, and then calculate her BMI, or body mass index, to help assess if she's maintaining a healthy weight. A healthy BMI is between the 5th and 85th percentiles for your child's age and sex. A child whose BMI is over the 85th percentile is overweight, and over the 95th percentile is considered obese.

What causes obesity?

Body weight is dependent on a complex interplay of genetics, energy intake (what we eat) and energy output (our activity). Some children may stay slender without any special effort, while others will require careful monitoring of eating, exercise, and screen time, to maintain a healthy weight.

What are the consequences of obesity?

As childhood obesity has increased dramatically in our country, we have begun to see children developing health problems that are associated with being overweight. Associated health problems include Type 2 diabetes, heart disease, high cholesterol, high blood pressure, asthma, sleep apnea, joint problems and psychological problems.

Our eating and activity habits are generally learned during childhood. Parents are the most important role models for children, so it is important that a family learn healthy eating and activity habits together.

How can obesity be prevented?

Follow these principles of healthy eating:

- Set a routine schedule of 3 balanced meals and 2 healthy snacks per day.
- Have all meals in the kitchen or dining room, with no TV.
- Eat breakfast EVERY morning.
- Serve fruits and vegetables at every meal. Aim for a minimum of 5 per day and more than one choice per meal.
- Choose whole grain and high fiber products.
- Choose lean meats, poultry, fish, lentils, beans and low-fat dairy products for protein.
- Have only healthy snacks in the house. Don't buy "junk" food for home – your child will get it elsewhere.
- Limit fast foods, juice, soft drinks and sports drinks. Drink water!
- Offer age appropriate portion sizes. Most parents are surprised to know that a good estimate of serving size is 1 Tablespoon per year of age. For a 4 year old, this is only a 1/4 cup.

Parents can also help in these ways:

- Let children get involved with food choices and preparation as they are developmentally able and interested. Learning good choices takes practice, and food preparation can be a fun activity for a child.
- Parents have control over the choices of foods available, but children have control over what and how much they eat. While it may be tempting to engage in "food fights" it is never successful and often causes long lasting unhealthy food associations.



- Praise your child for good choices in eating and exercise. Never shame your child about weight, diet or activity.
- Help your child develop a positive relationship with food. Food is needed for nourishment and normal growth and development. It should not be used for emotional consolation; your child needs a caring adult, not food, for comfort.
- Avoid making some foods “taboo”. There are some foods that are better for bodies than others, but foods are not “good” or “bad”. We all like our favorite food sometimes; it’s just not the basis of our daily diet. For families that have dessert, remember it is part of a meal and not a reward for behavior.
- Make meals fun! Strive to have at least one family meal per day to connect with family members and enjoy their company. Turn off the TV, talk to each other, tell jokes!

Follow these principles of healthy activity:

- Limit all screen time (TV, DVDs, computer, video games, Gameboy) to 1 to 2 hours per day MAX
- Limit screen time to common rooms of the home, not in the bedroom.
- Children under 2 years of age should be discouraged from watching any TV to allow healthy brain development.
- All children and their parents should have a minimum of 60 minutes of activity per day. This does not need to be continuous or structured, but should be fun. Plan family activities such as walks, hikes, biking, house and yard projects or outings to parks.
- Consider organized sports as children get older or classes in an activity the child enjoys such as gymnastics, swimming, dance, or martial arts.

If you believe your child is overweight:

Schedule an appointment with your doctor or nurse practitioner to discuss a healthy weight plan for your child. Call your local YMCA and ask about “healthy weight” programs for children.

More Information:

Books:

A Parent’s Guide to Childhood Obesity. A Road Map to Health. American Academy of Pediatrics; Sandra G. Hassink, MD, FAAP, Editor in Chief.

Food Fights. Winning the Nutritional Challenges of Parenthood Armed With Insight, Humor, and a Bottle of Ketchup. Laura A. Jana MD, FAAP and Jennifer Shu, MD, FAAP.

Internet sites:

American Academy of Pediatrics (AAP.org/obesity) – Information and links to many other helpful sites

Center for Disease Control (CDC.gov/obesity) – Click on Obesity and Overweight: Tips for Parents. Practical information and links to many other helpful sites.

We Can! (WeCan.nhlbi.nih.com) – National program for parents and caregivers with practical tips for helping children 8 to 13 years of age.

ChooseMyPlate.gov – Nutritional information and tips.

FruitsandVeggiesMatter.gov – Recipes and information about how to use fruits and vegetables.

How to Avoid Portion Size Pitfalls (cdc.gov/healthyweight/healthy_eating/portion_size.html) – Center for Disease Control site and game.

Roseola

What is roseola?

Roseola is a viral illness caused by the human herpesvirus-6. Roseola is common in children between six months and three years old. Your child has roseola if:

- Your child has a fine pink rash, mostly on middle part of the body.
- Your child had a high fever two to four days before the rash appeared. When the rash appeared, your child's fever went away.
- Your child was only a little sick during the time with fever and acts fine now.

How long does it last?

The rash lasts one or two days, followed by complete recovery. Some children have 3 days of fever without a rash.

How can I take care of my child?

No particular treatment is necessary. Roseola can be spread to another child until the rash is gone. Other children of this age who have been with your child may come down with roseola in about 12 days.

When should I call my child's health care provider?

Call IMMEDIATELY if:

- The spots become purple or blood colored.
- Your child starts to act very sick.

Call during office hours if:

- The rash lasts more than three days.
- The fever lasts more than four days.
- You have other questions or concerns.

Staph Infections

Staphylococcus aureus is a bacterium that is commonly carried on the skin or in the nose of healthy people. Approximately 30 percent of the population are colonized (the bacteria is present, but without infection) with staph bacteria. Staph bacteria can cause skin infections which are usually minor. These infections can be treated with topical antibiotics. However, staph bacteria can also cause serious infections such as pneumonia and post surgical wound infections.

Treatment:

Most staph infections respond well to treatment with antibiotics. However, some staph infections are resistant to common antibiotics. These infections are known as MRSA (methicillin resistant staph aureus.) Currently, about 45 percent of staph infections are methicillin resistant. MRSA can occur in hospitalized patients and can also be acquired outside of the hospital. MRSA can also cause community based infections occurring in the form of a boil or pimple. Sometimes these can cause large abscesses or blood stream infections.

Prevention:

Staph infections can be partly prevented by good hygiene. It is important to keep your hands clean by using soap and water or alcohol based hand sanitizers when exposed to someone with a skin infection. Keep cuts clean and covered until healed. Avoid contact with other people's wounds. Don't share razors and towels with others. If you think you have a staph infection, call your physician's office.

When should I call my child's health care provider?

Call during office hours if:

- Your child has pimples or sores that are red, painful and not going away after a few days.
- Your child has had MRSA in the past and develops new sores.

Teething

What is teething?

Teething is the normal process of new teeth working their way through the gums. Your baby's first tooth may appear any time between the time he is 3 months to 1 year old. Most children have completely painless teething. The only symptoms are increased saliva, drooling, and a desire to chew on things. Teething does not cause illness or fever.

Because teeth erupt almost continuously from 6 months to 2 years of age, many unrelated illnesses are blamed on teething. Fevers are also common during this time because after the age of 6 months, infants lose the natural protection provided by their mothers' antibodies. The fevers are not due to teething, however, but to infections.

How can I take care of my child?

Most babies need no special care while they're teething. Some babies like a cold teething ring or cold cloth to chew on.

COMMON MYTHS ABOUT TEETHING: Teething does not cause fever, sleep problems, diarrhea, diaper rash, or lowered resistance to any infection. It probably doesn't cause crying. If your baby develops a fever or other symptoms while teething, the symptoms are caused by something else.

When should I call my child's health care provider?

Call during office hours if:

- Your child develops a fever over 101°F.
- Your child develops crying that doesn't have a cause.
- You have other questions or concerns.

Tummy Time

The American Academy of Pediatrics recommends that babies play on their tummies. Time on the tummy helps babies develop the muscle strength to hold the head up and helps the eyes to work together. Babies need to push with their hands against a firm surface to help develop the strength to manipulate toys and crayons later.

Research suggests that babies who sleep on their backs and only play on their backs do not acquire the normal baby skills of rolling over and crawling as quickly as babies who spend floor time on their tummies every day. In addition, a variety of positions will help to avoid problems such as neck muscle tightness and flat spots on the head.

How much tummy time:

- Begin on their first day home from the hospital. Play and interact with the baby while he is awake and on the tummy 2 to 3 times each day for a short period of time (2 - 5 minutes), increasing the amount of time as the baby shows he enjoys the activity. A great time to do this is following a diaper change or when the baby wakes from a nap.
- Tummy time prepares babies for the time when they will be able to slide on their bellies and crawl. As babies grow older and stronger they will need more time on their tummies to build their own strength.

Points to consider:

- Time spent in a car seat is wasted time unless during transportation where straps provide safety
- Playing in all positions is important before 3 months; on back, on belly and on sides when directly supervised
- Sleep position should be on back until approximately 6 months when the baby can change positions independently.

Ideas for tummy time:

- **Tummy time is for babies who are awake and being watched.** Babies need this to develop strong muscles.
- Some babies may not like tummy time at first. Place yourself or a toy just out of the baby's reach during playtime to get him to reach for you or the toy.
- Place toys in a circle around the baby. Reaching to different points in the circle will allow him to develop the appropriate muscles to roll over, scoot on his belly and crawl.
- Lie on your back and place the baby on your chest. The baby will lift his head and use his arms to try to see your face.
- While sitting place the baby on your lap, this works well for burping too.

Vomiting

Cause

Most vomiting is caused by a viral infection of the lining of the stomach or by eating something which disagrees with your child. Often, a child whose vomiting is caused by a virus also has diarrhea. Sometimes children vomit from coughing hard.

Expected Course

The vomiting usually decreases or stops in six to twenty-four hours. Changes in the diet usually speed recovery. If your child has diarrhea, it may continue for up to two weeks.

Home Care for Vomiting

- 1. Offer small amounts of clear fluids for six to eight hours (no solid food):** Offer clear fluids (not milk) in small amounts until six to eight hours have passed without vomiting. For infants, give Pedialyte or an electrolyte solution. For older kids, you can use water, Pedialyte, diluted apple juice, diluted white grape juice, flat 7-Up or Jell-O.
Start with one teaspoon to one tablespoon of the clear fluid every 10 minutes. If your child vomits using this treatment, rest the stomach completely for one hour and then start over but with smaller amounts. This one-swallow-at-a-time approach rarely fails.
- 2. Offer bland foods after six to eight hours without vomiting:** After six to eight hours without vomiting, your child can gradually return to a normal diet.
Older children can start with such foods as saltine crackers, bread, bland soups, rice and mashed potatoes. Infants can start back on formula.
Usually your child can be back on a normal diet within 24 hours after recovery from vomiting.
- 3. Diet for breast-fed babies:** The key to treatment is providing breast milk in smaller amounts than usual. If your baby vomits occasionally, make no changes. If your baby vomits repeatedly, continue breast-feeding but nurse for a shorter period of time, every one to two hours.
As soon as six to eight hours have passed without significant vomiting, return to normal nursing. Pedialyte is rarely needed for breast-fed babies. If your baby is urinating less frequently than normal, you can offer the baby Pedialyte between breast-feedings for a short time (six to twenty-four hours).
- 4. Formula-fed babies:** If the vomiting is infrequent, it is okay to “feed on through.” If it is frequent (more than three or four times) stop the formula and any solids and give Pedialyte only in small amounts frequently as tolerated until the vomiting has decreased.
- 5. Medicines:** Do not give your child any medicines by mouth for six to eight hours. Oral medicines can irritate the stomach and make vomiting worse. If your child has a fever (greater than 101 degrees), you can use acetaminophen suppositories. Call your physician if your child needs to continue taking a prescription medicine.
- 6. Common mistakes in the treatment of vomiting:** A common error is to give as much clear fluid as your child wants rather than gradually increasing the amount. This is more likely to lead to continued vomiting.
- 7. For children over six months of age:** It is okay to give small amounts of diluted sports drinks (such as Gatorade) instead of Pedialyte.
- 8. Do not use any over-the-counter medications for vomiting unless directed by your provider.**



Call Your Child's Health Care Provider Immediately If:

- Your child shows signs of dehydration (such as no urine in over 12 hours, very dry mouth, no tears when crying).
- Your child vomits up blood.
- Your child starts acting very sick.

Call Your Child's Health Care Provider During Office Hours If:

- The vomiting continues for more than 24 hours if your child is under age two years or 48 hours if over age two.
- You have other concerns or questions.

Written by B.D. Schmitt, M.D., author of "Your Child's Health," Bantam Books. Copyright 2004 McKesson Health Solutions.

Assistance for Families

Family Resources

The Everett Clinic Center for Behavioral Health	425-339-5453
Compass Health/Family Counseling Services	425-349-6200
Parent Place.....	206-542-3421
Volunteers of America Crisis Line	425-258-4357

Child Care And Nutritional Information

Volunteers of America for Referrals.....	425-259-3191
Edmonds Community College for Referrals.....	425-640-1459
Everett Community College for Referrals	425-388-9100
Northwest Child Nutrition.....	425-339-3383
Providence Children’s Center	425-258-7311
YMCA of Everett	425-258-9211
YMCA of Marysville	360-653-9622
YMCA of Mukilteo.....	425-353-9622
YMCA of Southeast Everett.....	425-337-0123
Woman, Infants & Children (WIC).....	425-252-6491

See also Yellow Pages listing: Day Nurseries/Child Care Schools/Academies

Pregnancy Resources and Options

Catholic Community Services.....	425-257-2111
For the Kids Sake – Parenting Classes	425-493-9780
New Hope Child and Family Agency	206-363-1800
Lutheran Counseling Network	425-258-2955
Planned Parenthood.....	425-339-3389
Pregnancy Aid	425-252-6444

Parenting Resources

The Everett Clinic for Behavioral Health.....	425-339-5453
Compass Health	425-349-6200
Department of Social and Health Services	1-800-562-5624
Parents Without Partners.....	206-517-2700
Parent Trust for Washington Children.....	206-233-0156

Volunteer Opportunities

Division of Children and Family Services, Everett	425-339-4768
United Way of Snohomish County.....	425-921-3400
Volunteers of America	425-259-3191

2-1-1

**If you have a
life-threatening
emergency,
call 9-1-1.**

2-1-1 is the telephone number that connects you to health and human services in the community. There are hundreds of social services 2-1-1 can help you access, such as job training, food, shelter or support groups.

The North 2-1-1 call center is open Monday-Friday, from 8 am to 5 pm. If you are in a crisis that can't wait until the next business day, call the Crisis Line at 800-584-3578.

Phone Numbers You May Need

Emergency Room:

Providence Regional Medical Center Everett
Colby Campus 425-261-3000

The Everett Clinic Everett Campus

Family Medicine Department..... 425-339-5456
Pediatric Department 425-339-5450
Walk-In Clinic, 3927 Rucker Ave. 425-339-5422

The Everett Clinic at Harbour Pointe

Family Medicine Department..... 425-493-6004
Pediatric Department 425-493-6002
Walk-In Clinic, 4410 106th St. SW 425-493-6013

The Everett Clinic at Lake Stevens

Family Medicine Department..... 425-397-1704
Pediatric Department 425-397-1702
Walk-In Clinic, 8910 Vernon Road 425-397-1705

The Everett Clinic at Marysville

Family Medicine Department..... 360-651-7495
Pediatric Department 360-651-7492
Walk-In Clinic, 4420 76th St. NE 360-651-7497

The Everett Clinic at Mill Creek

Family Medicine Department..... 425-225-8004
Pediatric Department 425-225-8002
Walk-In Clinic, 15418 Main St., Ste. 200 425-225-8005

The Everett Clinic at Silver Lake

Family Medicine Department..... 425-357-3304
Pediatric Department 425-357-3300
Walk-In Clinic, 1818 121st St. SE 425-357-3305

The Everett Clinic at Snohomish

Family Medicine Department..... 360-563-8600
Pediatric Department 360-563-8600
Walk-In Clinic, 401 Second Street..... 360-563-8605

The Everett Clinic at Stanwood

Family Medicine Department..... 360-629-1504
Pediatric Department 360-629-1502
Walk-In Clinic, 7205 265th St. NW 360-629-1505

The Everett Clinic Answering Service 425-258-9000

Washington Poison Center 1-800-222-1222

General Information: Family Medicine and Pediatric Departments

Ages:

Both departments treat children and adolescents from birth through 21 years of age. In addition, the Family Medicine Department also sees adults.

Routine Physicals and Other Visits:

Please schedule appointments for these visits. Appointments for routine physicals are typically booked well in advance, so it is important to schedule your child's physical as early as possible. For re-checks and follow up of chronic problems, appointments will be scheduled at appropriate intervals.

Telephone Calls:

A receptionist usually is the first to answer your call and will either make your appointment or answer any questions you may have. If you have questions regarding health, she will transfer your call to one of our nurses. Each month we get thousands of telephone calls, so we may ask you to hold at times. You can help us decrease the waiting time by having this book handy. Many times this book will have just the answer you are looking for.

Literature:

Help yourself to patient literature and magazines available to you. Community notices of events and classes you might be interested in are posted.

Classes:

The Everett Clinic Newsletter will keep you posted as to dates, places, topics and other details regarding classes which are of interest to families. The Center for Behavioral Health has classes for adolescents and family issues.

To register for classes or for more information call 425-257-1440 or check our website at www.everettclinic.com under Patient Resources.

Missed Appointments:

Failure to cancel an appointment prevents someone else from receiving care. Please remember to call if you cannot make an appointment.

The Everett Clinic policy allows physicians the right to charge for missed appointments or to permanently discontinue care with any patient who misses two or more appointments. If you miss more than two appointments this may jeopardize your ability to be seen at any Everett Clinic location. If circumstances exist that make it difficult for you to keep your scheduled appointment, please bring this matter up with your health care provider and we will do our best to accommodate your needs.

Emergency Care

Life Threatening Emergencies:

We recommend that you **dial 911** and ask for assistance.

Acute Illness:

It is best to come to the office during regular hours if at all possible. If you have a specific question about your child, you may call the office between 7 a.m. and 6 p.m. on weekdays for telephone advice.

The Clinic has eight **Walk-In Clinics** (no appointment needed):

- EVERETT** - 3927 Rucker Avenue
- HARBOUR POINTE** - 4410 106th Street SW
- LAKE STEVENS** - 8910 Vernon Road
- MARYSVILLE** - 4420 76th Street NE
- MILL CREEK** - 15418 Main Street, Suite 200
- SILVER LAKE** - 1818 121st Street SE
- SNOHOMISH** - 401 Second Street
- STANWOOD** - 7205 265th Street NW

Occasionally, you may be referred to the Walk-In Clinic by your health care provider. On nights, weekends, and holidays when our Family Medicine and Pediatric Clinics are not open, there is always someone available by phone to assist you. For such urgent needs, the nurse or physician on-call may be reached by calling the Family Medicine or Pediatric Department, or the Answering Service at 425-258-9000.

If your child requires emergency hospital care, we recommend that you go to the Emergency Room at Providence Everett Medical Center.

Before seeking care at our Clinic during weekdays or after hours at the hospital Emergency Room, we recommend that you call the office or answering service first. This is particularly important for Emergency Room visits where your health insurance may require you to have preauthorization. (Don't hesitate to seek care for life-threatening conditions.) In addition to this booklet, we recommend that all parents have a copy of a basic child care book at home for reference.

Well-Child Exams

Recommended Schedule for Well-Child Exams

Listed at right is the recommended schedule for well-child exams. Not all insurance plans cover the recommended schedule below so please check with your insurance company. At each well-child visit, your child's growth, development and physical health will be evaluated. Other topics such as nutrition, behavior, discipline, sleep and safety may be discussed. If needed, immunizations will be administered. Visits to the health care provider when your child is ill do not substitute for routine well-child care.

3-5 days old.....	Newborn exam
7-30 days old.....	Well-child exam
2 months old	Well-child exam
4 months old	Well-child exam
6 months old	Well-child exam
9 months old	Well-child exam
12 months old	Well-child exam
15-18 months old.....	Well-child exam
2 years old.....	Well-child exam
3 years old.....	Well-child exam
4 years old.....	Well-child exam
5 years old.....	School physical exam
5-18 years old.....	Physical exam every 1-2 years

Immunizations

Why immunize your child?

TO PROTECT your child and his contacts from serious diseases, such as measles, polio and whooping cough. In this country we have very little of the diseases for which we have immunizations because we have large numbers of our children and adults protected. Because of immunization, smallpox has been eliminated from the world, polio has been eliminated from most of the world, and what used to be a common cause of meningitis in babies, Hemophilus influenza type B, has become uncommon in this country. If we do not keep the number of people immunized high, we will see the preventable diseases return.

What about side effects?

In recent years people have become concerned about the safety of some of the vaccines. Over the years the vaccines have been improved to minimize any possibility of side effects, so that now the chance of a significant reaction is probably less than 1/100,000. That is extremely rare!

And it has also been found that some conditions, such as autism, are not related to vaccines. It now appears that autism is mostly genetic, and not related to immunizations. People have also been concerned about mercury (used as a preservative) in vaccines. Even though it was never scientifically shown to put children at risk, it is no longer in any of the vaccines used in young children.

What can you do?

Please make sure that your child is current on his immunizations. If you have any concerns about the safety of any of the immunizations, ask your pediatrician or family doctor. He or she will be happy to discuss them with you. We can also provide you with reference material regarding the different vaccines, including web sites that provide an in depth discussion.

Thank you!

Immunization Schedules

Recommended Immunization Schedule for Ages 0-6 Years

UNITED STATES 2011

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series should be administered no earlier than age 24 weeks.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months 0 days.
- If Rotarix is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should not be used for doses at 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- A single supplemental dose of PCV13 is recommended for all children aged 60 through 71 months with underlying medical conditions who have received an age-appropriate series of PCV7.
- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See MMWR 2010;59(No. RR-11).
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010–2011 seasonal influenza vaccine. See MMWR 2010;59(No. RR-8):33–34.

8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

9. Varicella vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

11. Meningococcal conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

Vaccine ▼	Age ►	Birth	1 Month	2 Months	4 months	6 months	12 Months	15 Months	18 Months	19-23 Mos.	2-3 Years	4-6 Years
Hepatitis B ¹		HepB	HepB			HepB						
Rotavirus ²				RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	see footnote ³	DTaP				DTaP
Haemophilus influenzae type b ⁴				Hib	Hib	Hib ⁴		Hib				
Pneumococcal ⁵				PCV	PCV	PCV		PCV				PPSV
Inactivated Poliovirus ⁶				IPV	IPV		IPV					IPV
Influenza ⁷							Influenza (Yearly)					
Measles, Mumps, Rubella ⁸							MMR			see footnote ⁸		MMR
Varicella ⁹							Varicella			see footnote ⁹		Varicella
Hepatitis A ¹⁰							HepA (2 Doses)					HepA Series
Meningococcal ¹¹												MCV4

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

 Range of recommended ages
 Certain high-risk groups

Check with your doctor, nurse or clinic about the best schedule for your child. This schedule is subject to change.



Recommended Immunization Schedule for Ages 7-18 Years

UNITED STATES 2011

Vaccine ▼	Age ►	7-10 Years	11-12 Years	13-18 Years
Tetanus, Diphtheria, Pertussis ¹			Tdap	Tdap
Human Papillomavirus ²	see footnote 2		HPV (3 Doses) (females)	HPV Series
Meningococcal ³		MCV4	MCV4	MCV4
Influenza ⁴		Influenza (Yearly)		
Pneumococcal ⁵		Pneumococcal		
Hepatitis A ⁶		HepA Series		
Hepatitis B ⁷		HepB Series		
Inactivated Poliovirus ⁸		IPV Series		
Measles, Mumps, Rubella ⁹		MMR Series		
Varicella ¹⁰		Varicella Series		

This schedule includes recommendations in effect as of December 21, 2010. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

 Range of recommended ages
 Catch-up immunization
 Certain high-risk groups

Check with your doctor, nurse or clinic about the best schedule for your child. This schedule is subject to change.

- Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Persons aged 11 through 18 years who have not received Tdap should receive a dose followed by Td booster doses every 10 years thereafter.
 - Persons aged 7 through 10 years who are not fully immunized against pertussis (including those never vaccinated or with unknown pertussis vaccination status) should receive a single dose of Tdap. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
 - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
 - Quadrivalent HPV vaccine (HPV4) or bivalent HPV vaccine (HPV2) is recommended for the prevention of cervical precancers and cancers in females.
 - HPV4 is recommended for prevention of cervical precancers, cancers, and genital warts in females.
 - HPV4 may be administered in a 3-dose series to males aged 9 through 18 years to reduce their likelihood of genital warts.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Meningococcal conjugate vaccine, quadrivalent (MCV4).** (Minimum age: 2 years)
 - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
 - Administer 1 dose at age 13 through 18 years if not previously vaccinated.
 - Persons who received their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 years.
 - Administer 1 dose to previously unvaccinated college freshmen living in a dormitory.
 - Administer 2 doses at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
 - Persons with HIV infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
 - Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
 - Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years (if first dose administered at age 2 through 6 years) or after 5 years (if first dose administered at age 7 years or older).
- Influenza vaccine (seasonal).**
 - For healthy nonpregnant persons aged 7 through 18 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used.
 - Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
 - Children 6 months through 8 years of age who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See MMWR 2010;59(No. RR-8):33-34.

- Pneumococcal vaccines.**
 - A single dose of 13-valent pneumococcal conjugate vaccine (PCV13) may be administered to children aged 6 through 18 years who have functional or anatomic asplenia, HIV infection or other immunocompromising condition, cochlear implant or CSF leak. See MMWR 2010;59(No. RR-11).
 - The dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7.
 - Administer pneumococcal polysaccharide vaccine at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with functional or anatomic asplenia or an immunocompromising condition.
- Hepatitis A vaccine (HepA).**
 - Administer 2 doses at least 6 months apart.
 - HepA is recommended for children aged older than 23 months who live in areas where vaccination programs target older children, or who are at increased risk for infection, or for whom immunity against hepatitis A is desired.
- Hepatitis B vaccine (HepB).**
 - Administer the 3-dose series to those not previously vaccinated. For those with incomplete vaccination, follow the catch-up schedule.
 - A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB is licensed for children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- Measles, mumps, and rubella vaccine (MMR).**
 - The minimum interval between the 2 doses of MMR is 4 weeks.
- Varicella vaccine.**
 - For persons aged 7 through 18 years without evidence of immunity (see MMWR 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>). Department of Health and Human Services • Centers for Disease Control and Prevention

**The Everett Clinic
Everett Campus**
3901 Hoyt Avenue
Everett, WA 98201
425-259-0966

**The Everett Clinic at the
Medical Office Building**
1330 Rockefeller Avenue
Everett, WA 98201
425-259-0966

**The Everett Clinic
at Harbour Pointe**
4410 106th Street SW
Mukilteo, WA 98275
425-493-6000

**The Everett Clinic
at the Pavilion**
900 Pacific Avenue
Suite 500
Everett, WA 98201
425-339-5430

**The Everett Clinic
at Lake Stevens**
8910 Vernon Road
Everett, WA 98205
425-335-0966

**The Everett Clinic
at Silver Lake**
1818 121st Street SE
Everett, WA 98208
425-357-3300

**The Everett Clinic
at Marysville**
4420 76th Street NE
Marysville, WA 98270
425-651-7490

**The Everett Clinic
at Snohomish**
401 Second Street
Snohomish, WA 98290
360-563-8600

**The Everett Clinic
at Mill Creek**
15418 Main Street
Suite 200
Mill Creek, WA 98012
425-225-8000

**The Everett Clinic
at Stanwood**
7205 265th Street NW
Stanwood, WA 98292
360-629-1500

Please keep this book for future reference.

It contains important information which will assist you in caring for your child during illnesses and minor emergencies. For more information on any of these topics, or other health-related issues, please visit www.everettclinic.com/healthwise.

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