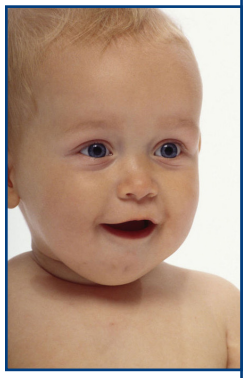
SPA



7900 FM 1826

BLDG 1, Suite 220

Austin, Texas 78737

P | 512 288.9669

F | 512 498.0317

Taking Care of Your

Newborn

SPA

A baby is born with a need to be loved and never outgrows it.

– Frank A. Clark

Southwest Pediatric Associates

Kelly Jolet, M.D., F.A.A.P. | Vaishalee Patil, M.D., F.A.A.P.

Haydee Rimer, M.D., F.A.A.P. | Christine Fyda, D.O. | Nicholas Wagner, M.D.

Taking Care of Your

Newborn

We hope this booklet will serve you well as a guide to common symptoms and concerns. We have attempted to gather the latest information available and provide you with information that reflects our knowledge and experience as well as the latest recommendations from sources such as the American Academy of Pediatrics (AAP) and the Centers for Disease Control (CDC).

At the time of the printing, this information was as up-to-date as possible. We have included websites that links that are subject to change. We will continue to make changes as new recommendations are noted, or as our experience dictates. For the latest version of this booklet, please check our website at **www.swpedi.com** and look under "Helpful Links." This booklet will always be posted there in its most up-to-date form.

Table of Contents

Table of Contents

Welcome

Welcome to Southwest Pediatric Associates! We know how important it is for you to have confidence in the care your children receive from their doctor. We consider it an honor to care for your family. Our goal is to join our medical expertise with your intimate knowledge of your child, resulting in a team approach to the health and well-being of your child.

Despite our diverse backgrounds, you will find that we practice pediatrics in a very similar way. We strive to remain current in our continuing medical education, and use new medical research to complement time-tested methods and experience. We focus much of our energy on preventive health measures, including vaccines, developmental screening as well as assistance with common parenting concerns.

We provide the majority of pediatric care at Seton Southwest Hospital Labor and Delivery. In rare instances, we may be called from the hospital to provide emergency care during her birth, or for a newborn that has become ill, but we will make every effort to minimize delaying your appointment due to these unusual circumstances.

As faculty of The University of Texas Medical Branch, we offer clinical training for pediatric residents at Dell Children's Hospital. Your child may occasionally see a pediatric resident here at our clinic, but please be assured that your child will always see one of us as well. The pediatric resident is a physician, a medical school graduate, who is now receiving specific pediatric training. If you would prefer to not see a resident physician, please let the front desk know in advance.

We do not employ nurse practitioners or physician assistants. In our office, your child will always see a pediatrician for each visit.

Our Physicians

All of our physicians are board certified by the American Board of Pediatrics and are Fellows of the American Academy of Pediatrics. We carry privileges at Dell Children's Hospital and the Seton Family Hospitals.

Kelly Jolet, MD FAAP

Dr. Jolet was Board Certified in 1996. She grew up in San Antonio, where she graduated Magna Cum Laude from Our Lady of the Lake University with a degree in Biology. She graduated from the University of Texas Medical School at Houston where she was inducted into the Alpha Omega Alpha Honor Society. She completed her pediatric residency at the Naval Medical Center San Diego. Following residency, she served as an active duty Navy Pediatrician for 4 years in Central California. Upon completion of her Navy tour she returned home to Central Texas, and served as pediatric staff at the Children's Hospital of Austin and Austin City Clinics. In 2001, she formed Southwest Pediatric Associates with Dr. Patil and Dr. Rimer. Dr. Jolet and her husband have three school-age children, 2 daughters and 1 son.

Vaishalee Patil, MD FAAP

Dr. Patil was Board Certified in 2001. A native of India, she graduated from Grant Medical School, with honors. She completed a residency in Obstetrics and Gynecology at Sir J.J. Hospital, and became Board Certified in Obstetrics and Gynecology. After working as an Obstetrician and Gynecologist for several years, she got married and moved to the United States, where she completed a second residency, this time in Pediatrics, at Henry Ford Health Systems in Detroit, Michigan. After residency, she formed Southwest Pediatrics with Dr. Jolet and Dr. Rimer. She is fluent in Marathi, Hindi and Gujrati dialects. Dr. Patil and her husband have two school-age sons.

Haydee Rimer, MD MPH FAAP

Dr. Rimer was Board Certified in 2001. A native of Venezuela, she graduated Magna Cum Laude from the Universidad de Los Andes. After medical school, she completed a research fellowship at The Center for Vaccine Development at the University of Maryland, and received her Masters in Public Health from Johns Hopkins University. She completed her pediatric residency at Texas Tech University, El Paso. After residency she served as faculty at the City of Austin clinics. In 2001, she formed Southwest Pediatric Associates with Dr. Patil and Dr. Jolet. Dr. Rimer is fluent in Spanish. Dr. Rimer and her husband have an adult daughter and a school-age son.

Christine Fyda, DO

Dr. Fyda joined Southwest Pediatric Associates in December, 2009. She is originally from Buffalo, NY and graduated from Colgate University where she majored in Biology and played Division 1 volleyball. She graduated from medical school at Touro University College of Osteopathic Medicine in California. She came to Austin, TX in 2006 and has recently completed her pediatric residency from UTMB at Dell Children's Hospital. During her medical school and residency training she had the opportunity to work in clinics in Tonga and Costa Rica. Dr. Fyda is Board Eligible. She is very excited about the newest member of her family, a nephew that lives in Dallas.

Nicholas Wagner, MD

Dr. Wagner is the newest member of our SW Pediatric family, joining us in August 2011. You may recognize him, however, as his role as a resident physician in our practice over the last 3 years. He grew up in California and Georgia and is now happy to call South Austin home. Dr. Wagner completed his undergraduate work in Biology and Chemistry at University of North Carolina at Chapel Hill and remains an avid Tar Heel basketball fan. He returned to Georgia for medical school at the Georgia Health Sciences University. He completed his residency at UT Southwestern - Austin, based out of Dell Children's Hospital. When he is not in the office, he can be found enjoying Austin's local music scene, trying to discover the best new food trailer, or at Town Lake with his wife and mischievous rescue dog, Ivy.

Practice Policies

Our practice is dedicated to providing not only the best patient care, but also excellent customer service. If that any time, you have a suggestion, or we do not meet your expectations, please ask to speak with the practice manager.

The following policies are in place to ensure efficient and prompt handling of the administrative issues surrounding health care.

Referrals

When your physician makes a referral, we often must submit the referral to your insurance company for processing. This process may take up to 10 days depending on the responsiveness of your insurance company. If the referral is needed more urgently, we will individually expedite that referral, as your insurer allows. We have a referral coordinator whose primary job is to help us connect your child with a specialist that accepts your insurance.

Lab Results

Lab results are relayed to you either by phone or mail within 10 business days of the results. Some particular tests may take longer, and we will communicate that to you when necessary. Abnormal results are generally called directly by the physicians to the parent or patient, while normal results are conveyed by the medical assistants. If you have not received laboratory results within 10 days of your appointment, please feel free to give us a call.

Prescription Refills

When you need refills on a prescription, please contact your pharmacy directly and request a refill. Calling us first actually slows the process down. The pharmacy will fax us a request and we will review it and fax it back. Please allow 3 to 5 business days to obtain the refill.

Controlled substances are handled slightly differently. These medications, such as Ritalin, Adderall, etc., are regulated by the Drug Enforcement Agency. By law, these prescriptions expire after 21 days and can not be requested by fax or phone. You must physically pick up a written prescription and deliver it to the pharmacy. Some mail order pharmacies will allow us to provide 90 day supplies.

Financial

Payment is expected at the time services are rendered. If you have insurance coverage, we are happy to provide the service of filing your claim. You will be responsible for your copayment, co-insurance and/or deductibles required by your insurance. Remember that insurance coverage is a contract between you and the insurance company and every carrier has unique rules and regulations. Although we try to stay very current on what is considered covered, these rules can change quickly and there are things that we simply cannot anticipate. We encourage you to be very proactive in talking with your insurance company about what is covered, in advance, as much as possible. We are pleased to accept cash, personal check, Visa, Master Card, Discover and American Express.

Phone Calls

We welcome your questions. New parents have many concerns that a simple phone call can relieve. We have a nurse or medical assistant assigned to the phones at all times. While we would love for your call to be answered by a real person every single time, this is not always practical. If you called for a concern and have left a message with the triage nurse, we have set a standard for them to call you back within 4 hours. Unfortunately, occasional call volumes exceed our abilities to keep up with them. If you have called and left a message, are worried and cannot wait for the return phone call, please call back and make an appointment with the doctor or ask for the triage nurse to be notified of your concern. Calls to the triage nurse are, of course, free of charge. Calls received after 4pm may not be returned until the following day.

After-hours calls are handled a bit differently. When the office is closed, you can call us and use the phone tree asking for "medical advice." This will be transferred to MedLink for the physician to be paged. You may also reach MedLink directly at (512) 323-5465. After 10:00pm you may use the same call-in procedure, but calls are transferred to the Seton Call Center where a registered nurse will assess the severity of the symptoms, give advice according to current pediatric protocols and contact the doctor as needed. Because of the expenses associated with these call services, there is a nominal $15 fee to cover these expenses.

We do not share call with another pediatric group, so after-hours calls will always come to our group. We review all the calls for the evening or weekend with the primary pediatrician, so that we keep your doctor updated on your child.

During after-hours calls, we may not have access to the medical record, so please be ready to discuss significant past medical history with the on-call physician as we make decisions. Hopefully, the following tips will help us help you most efficiently.

1. Please call during office hours for general questions. Use the after-hours

service for urgent questions only. Do not call for refills after-hours. Do not call for chronic issues (constipation, ADHD, eczema) unless there is a sudden, concerning change.

2. Please take your child's temperature (we prefer rectally if under one year in age) before you call for advice about a sick child.

3. Please be prepared to take notes on the advice you receive. Have a pencil and paper handy.

4. Have your preferred pharmacy name and number ready when you call.

5. Save non-urgent questions for your baby's next check-up. Write them down as you think of them and bring your complete list to your baby's next appointment. We enjoy discussing these minor but important concerns with you face-to-face whenever possible.

Baby Proofing & Home Safety

POISON CONTROL HOTLINE: 1-800-POISON-1

It is never too early to "baby-proof" your home. Accidents are a leading cause of death in infants and young children. You can begin this process of reducing the potential hazards in your home during your pregnancy, and continue the process even before your baby can move around the house.

We have specific handouts about baby-proofing and safety at each well child exam, but for now, here are some things you can think about:

- Older siblings and pets are unpredictable and require supervision, no matter how reliable you think they are. Never leave your infant unattended while in the company of older siblings or pets. Older siblings also often have toys with small parts that are choking hazards. Think about small lego pieces, Hot Wheel tires, Barbie or Polly Pocket shoes, or even pony-tail holders/barrettes.
- Begin moving cleaning supplies and other hazardous chemicals out of reach (for example, above the washing machine/dryer).
- Begin installing baby-resistant latches by at least 4 months of age.

- We DO NOT recommend syrup of ipecac for poisoning. If your child ingests something poisonous, please call poison control for advice immediately.
- Periodically, get on the floor and see your home environment from the eyes of your young child or infant. You might be surprised at what hazards you can find from their perspective that we miss from ours.
- Sometimes the biggest hazards are when visiting family and friends who aren't quite so safety-conscious. Think about where medications and cleaning supplies are stored where you visit and make appropriate adjustments.

Periodically we will give you a home safety checklist. Please ask for it early if you would like it. Take the time to review these safety handouts and adjust your home environment accordingly.

Bathing & Skin Care

For the first few days to weeks, all your baby needs is a sponge bath every few days. The hands, diaper area and neck will need daily attention, but a full bath can be less frequent. After the cord has fallen off and the residual discharge is minimal, you can give your baby a tub bath.

Most babies do well in a sink, but you can use a special baby bath. Have all your equipment ready before you put your baby in the tub. Never leave your baby alone in the bath, even for a few seconds. Always check the water temperature before your baby's skin touches the water. Baby skin is extremely sensitive and burns can occur easily. If you can tolerate the temperature with the back of your fist, the temperature is safe for the baby. Consider turning the hot water heater temperature down to avoid scalding injuries.

Most soaps marketed for babies are actually very drying to their skin. We find that Dove Sensitive bar is actually better for baby skin than Baby Magic or Johnson's Head-to-Toe, for example. Any baby shampoo that is gentle on the eyes is fine for the hair. Always rinse your baby well to avoid leaving soap residue, which can be irritating.

Soap is unnecessary in the vaginal area for girls, and can irritate this sensitive area. Remember to wipe little girls from front to back to avoid bringing stool forward into the genital area.

Initially, most babies seem very dry for the days and weeks after birth. This is a normal adjustment to life outside, as they were in water for 9 months. It is usually best to avoid creams, ointments or baby oil because these can be extremely irritating. If the skin seems cracked the point of bleeding, use a little Vaseline, Aquaphor or Lubriderm to these areas as needed.

Toenails and fingernails grow quickly. You may clip, scissor or file the nails; everyone seems to have their own preference. Parents usually find clipping the nails easiest on a very sleepy baby. Put a light source on their other side of their hand to help you see through to the nail bed and help you avoid clipping their tender skin. Try to round the corners of the fingernails to avoid scratches. Mittens are fine for a few days, but babies need to use their hands to explore from an early age. Keeping the nails short and clean is a better way to avoid scratches than mittens over time. Remember to cut toenails straight across to avoid ingrown toenails.

BOWEL MOVEMENTS: What is normal?

Frequency and consistency of the baby's bowel movements are a common concern for parents. After the first few days and the meconium (black tarry stools) have passed, the stool generally changes to green then to a yellow, mustard color, often accompanied with small formed elements that look "seedy." These mature stools are often quite runny, especially in a breastfed baby, and occur quite frequently.

This pattern tends to change, however, and by several weeks to months, the stools become less frequent. Some babies by two to three months of age do not have a bowel movement daily. In fact, some breastfed babies go up to five to seven days between bowel movements. We are more concerned about the consistency of the stool than the frequency. If a stool is fairly soft and easy to pass, it is not constipation, even if it has been a week since the last bowel movement. Parents also often worry about straining that babies often do while they pass a bowel movement. This is generally quite normal, despite how dramatic it may seem.

PLEASE CALL US IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS REGARDING YOUR BABY'S STOOL:

- Does the stool look like little pebbles or rocks, or is it quite large (wide/thick)?
- Is the stool extremely difficult to pass?
- Is there any blood?
- Do you feel that the baby is in pain when he/she has a bowel movement?
- Are the stools infrequent AND clay-like in consistency?
- Does the belly seem distended?
- Has the baby's intake decreased recently?
- Have the stools turned dark (i.e. black) and/or tarry?
- Are the stools white or chalky?

BREAST-FEEDING

We are very strong advocates for breast feeding. We want you to be successful and reach your own breast feeding goals, whatever they may be. The benefits of breast feeding are too numerous to mention, but include medical benefits for both mother and baby, immunological protection for the baby during a critical period, and actually increases your baby's learning capacity (IQ). We are happy to assist you with your breast-feeding, and are very happy to work with the nursing staff and lactation consultants at the hospital, as well as private lactation consultants after you leave the hospital. We would certainly also support your decision to not breast feed, if this is the best option for you.

The following is a summary of some very common breast-feeding concerns. For more in-depth information, we recommend *The Nursing Mother's Companion* by Kathleen Huggins.

THE FIRST 24 HOURS

Nurse as soon after birth as possible. Try to get eight to ten feedings in during the first day. Wake the baby every three to four hours if he or she is very sleepy, but otherwise feed on demand. Your milk supply is encouraged by how quickly you begin nursing and how often you nurse. Avoid using a bottle until your nursing is well established to avoid possible confusion. Most of the time formula supplementation is not necessary.

Ask your nurse to assist you to help the baby latch on if it is painful or difficult. It is normal to be a little sore, but if this persists or you are in pain, consult with your doctor. A proper latch is the key to successful breast feeding and prevention of sore nipples. Pure lanolin cream and/or a cold pack/gel pack can help with soreness as well. After a feeding, make sure your breasts are very dry before putting on a clean breast pad and bra.

A feeding can be as short as five to ten minutes or last up to 40 minutes. The colostrum your baby is receiving is extremely good for your baby. You may not feel the baby is getting very much fluid, but he or she doesn't need very

much for the first few days. Small amounts of colostrum with each feeding are all that are necessary. A baby that wants to stay on the breast more than 40 minutes per feeding may have a strong need to suck, and a pacifier may be a good solution for these babies. If your breast feeding is going well, you need not worry about confusing your baby by offering a pacifier. Some babies have a very strong need to suck, and using a pacifier is fine as long as the baby needs to suck after what seems to be a good feeding.

Do not hesitate to ask for assistance from your nurses. They are there to help you. A lactation consultant may be helpful if you are having difficulty starting to breast feed. This service may not be covered by insurance, but it is generally worth the expense if you desire to breast feed. The most important thing to remember is that breast feeding is a learned skill that requires practice for both you and your baby. Sometimes the learning process is difficult, but we will do whatever we can to help you succeed if you wish to breast feed.

THE FIRST FEW DAYS

The baby should continue to nurse approximately eight times per day to continue to encourage a good milk supply. Feeding frequency may be every one to 3 hours, depending on the baby's needs, which change from day-to-day. Do not be concerned if there does not seem to be a "schedule" emerging, especially for the first few weeks. Wake your baby if he or she sleeps more than three to four hours during the first few days. After you know that your baby's weight is stabilizing (usually by ten to 14 days) you can let your baby sleep longer at night if he or she is willing. If you offer formula to your baby during this critical time, the baby typically nurses less and your body gets the signal to make less milk. If you absolutely must give formula, only give one-half to one ounce of formula after a breast feeding, unless directed otherwise by your physician.

Some babies may need supplemental formula or expressed breast milk/ colostrum if they are ill, weight loss is excessive, jaundice is severe or there are concerns about low blood sugar. We will help you make these decisions on an individual basis.

You may notice the first growth spurt occurring at approximately ten to 14 days. You may feel that suddenly you are not making enough milk because your baby seems hungrier. Your baby is simply teaching your body to make more milk, and the extra stimulation to the breast accomplishes this. A growth spurt generally only lasts one to two days. Babies also commonly "cluster feed," meaning they have several feedings close together. This is quite normal. Sometimes the cluster is at night, which is difficult when you are tired. Gradually increase the daytime feedings with waking the baby every two hours or so, and these night cluster feedings will diminish with time. Day/night confusion is extremely common in the first few days to weeks and will get better with time.

Do not worry if breast feeding remains somewhat difficult for up to a week or two. It may take several weeks for you to feel very confident and sure that your baby is doing well. Sometimes an early check up (at three to five days) is very helpful to check the weight and assure yourself that things are going well. Try to feed your baby when you first notice his or her hunger cues and before he or she becomes upset. Some common hunger cues include turning the head and searching with an open mouth and putting the fist in the mouth. If the baby is showing these signs immediately after what seems to have been a good feeding, consider offering a pacifier to see if the need is really for sucking rather than hunger. Again, if your breast-feeding is going reasonably well, offering a pacifier will not interfere with the latch. Ask for help if your baby seems constantly hungry.

Please see our website for links to lactation consultants that would work with frequently.

WAKING A SLEEPY BABY

Sometimes it is very difficult to wake a sleepy baby, especially in the first few days to weeks. If you need to wake your baby for a feeding, here are some helpful hints:

- Hold the baby sitting up
- Move the baby gently side to side or up and down

- Talk to your baby
- Change the baby's diaper
- Undress the baby except for the diaper
- Give your baby a sponge bath
- Stroke your baby's back, legs, arms, etc.
- Burp the baby
- Take your baby outside

When Do I Need to Offer a Bottle?

If you would like your baby to take a bottle with expressed breast milk or formula while you are separated, it is best to wait until your baby is latching on to the breast very easily and nursing is comfortable for you. Usually this occurs by about two weeks of age. You can pump or hand-express a small amount after a breast feeding and save the breast milk for later feedings. Often a baby will take a bottle, even with expressed milk, better from the father or another caregiver. If you plan to return to work or simply would like to be able to have the option of bottle feeding expressed milk periodically, we have learned that it really is essential to offer the baby a bottle within 2-3 weeks of age or they will have great difficulty accepting a bottle later.

Can I have alcohol or caffeine while breast feeding?

The answer to this question really focuses on moderation.

Small amounts of alcohol (no more than a glass of wine, a beer, for example) are considered safe while breast feeding. If you are choosing to drink more than this, please breastfeed with caution. Certainly it would be preferable to nurse your baby immediately prior to drinking any alcohol to reduce the baby's exposure. As a general rule, no more than 1-2 drinks per day is considered heavier drinking, and is not recommended. Over-the-counter products such as "Milk Screen" are available to quickly detect the presence of alcohol in your breast milk and may reassure or caution you in terms of nursing after consuming alcohol.

Caffeine intake during breast feeding is considered safe, but again, in moderation. Caffeine is a powerful central nervous system stimulant, and

it can interfere with your or your baby's body clock and make him or her restless or irritable. Consider limiting your intake to 1-2 servings per day.

Car Seats

All children should be properly restrained for every trip in the car, no matter the distance. Research clearly indicates that properly restrained children have a much decreased risk for serious injury and death.

For now, please remember that your baby needs to be in a rear-facing car seat until 12 months AND they weigh at least 20 pounds. You may safely turn them around when these milestones are reached, but feel free to leave them rear-facing as long as possible. Don't even think about a booster seat until a minimum of 4 years. Many 5-point-harness seats accommodate larger children, and this is ideal to use as long as possible. Texas law requires children 4-8 years of age to be in at least a booster seat at all times, and a 5-point harness exceeds those safety standards.

Make a point of checking the length/height restrictions for rear-facing infant carrier carseats. Many only accommodate up to 28-29 inches, which may occure by 6-9 months in some babies. If so, choose a convertible seat that you can keep reversed until 1 year, then turn forward-facing.

The chart below is a quick guide for terminology and which seat is best for each age. However, it's important to read more about the features and how to use your car safety seat. For detailed information, especially because information does change from time to time, please check www.aap.org/family/carseatguide.htm for the latest information.

AGE	TYPE OF SEAT	GENERAL GUIDELINE
Infants	Infant Seats and rear-facing convertible seats	All infants should always ride rear-facing until they are at least 1 year of age and weigh at least 20 pounds.
Toddlers/ Preschoolers	Convertible seats	It is best to ride rear-facing as long as possible. Children 1 year of age and at least 20 pounds can ride forward-facing.
School-aged children	Booster seats	Booster seats are for older children who have outgrown their forward-facing car safety seats. Children should stay in a booster seat until adult belts fit correctly (usually when a child reaches about 4'9" in height and is between 8 and 12 years of age).
Older children	Seat Belts	Children who have outgrown their booster seats should ride in a lap and shoulder belt in the back seat until 13 years of age.

When using a rear-facing seat, keep the following in mind:

- Make sure the car safety seat is installed tightly in the vehicle and that the harness fits the child snugly.
- Never place a rear-facing car safety seat in the front seat of a vehicle that has an active front passenger air bag. If the air bag inflates, it can cause serious injury or death.
- READ and FOLLOW the information guide that comes with your car seat. It is vital to insure proper placement and installation.
- Be sure the car safety seat is installed tightly. If you can move the seat more than an inch side to side or front to back, it's not tight enough.

If you are unsure if your infant's seat is properly installed, or you would simply like to confirm it, check http://www.seatcheck.org/. This organization lists agencies that will check your car seat free of charge – and you can search by zip code.

CHECK-UP SCHEDULE

At well child visits (check-ups), your pediatrician will assess your child's overall wellness. The vaccine schedule and well child schedule have been adjusted to coincide as much as possible. Your child will not necessarily receive vaccines at every well visit, but it is an excellent opportunity to weigh, measure, discuss concerns or questions, and give you guidance about safety issues and the next stage of development.

YOUR BABY NEEDS A CHECK UP AT:

❑	3-5 days
❑	2 weeks
❑	2 months
❑	4 months
❑	6 months
❑	9 months
❑	12 months
❑	15 months
❑	18 months
❑	2 years
❑	2 ½ years*

(this visit is recommended,
but not always covered by insurance)*

Annually, preferably around their birthday

Circumcision: Yes or No?

This is a very personal decision, and we will respect whatever choice you make for your son.

Circumcision does provide some very limited medical benefits, including the reduction in the risk of urinary tract infections in infant boys and penile cancer in elderly men. Interestingly, the Centers for Disease Control are expected to recommend routine circumcision due to the reduction in STD transmission from men who were circumcised. Despite the limited medical benefits and the likely CDC recommendation, the American Academy of Pediatrics has remained neutral rather than recommending the procedure. The AAP statement takes into consideration the fact that the decision is often based on religious or social reasons, rather than primarily medical concerns, and reflects the opinion that the limited medical benefits do not seem to support universal circumcision.

Circumcision Care

Care of the circumcised penis is quite simple. After the procedure, apply petroleum jelly on a fresh gauze pad with each diaper change. We recommend that you continue applying fresh Vaseline gauze pads with each diaper change for 3 to 5 days after the procedure.

The exception is if your child has had a Plastibel procedure, in which case no dressing is required. The plastic ring generally falls off at roughly 5 to 7 days after the procedure. Do not forcibly remove it, but let it fall off naturally.

After circumcision, a small amount of yellow or green material is noted on the circumcised surface. A small amount of discharge is normal and a small amount of bleeding can occur on the first day. Infections are quite rare, but might be recognized by a red blush that extends toward the body. Notify us immediately if spreading redness is noted, if there is excessive bleeding, or if there is no urine output within 24 hours of the procedure.
Natural secretions and shed skin cells form a white, cheesy substance, known as smegma. Occasionally, this can collect under the skin and

look like small pearls, often near the junction where the circumcision was performed. These may painlessly rupture at any point. As your son grows older, glands will begin to secrete oil that prevent the buildup of smegma.

Occasionally folds of skin may adhere to the circumcision site, causing tight adhesions to a portion of the penis. Gentle traction during bathing may decrease these adhesions. Please do not force them apart, and let us know at your next well-child exam if you are concerned.

Care of the Uncircumcised Penis

The care of the uncircumcised penis is also quite simple. The foreskin will eventually be able to retract all the way behind the glans of the penis, but it may take up to several years. The separation may be partial initially, but not be complete until adolescence. Nearly all boys can retract the foreskin fully as teenagers. Never force the skin back, as, bleeding, and pain can occur. Gentle traction during bath time can help the process, but again, do not force it.

After the foreskin is able to retract, make cleaning under the foreskin a normal part of bathing. The skin can be retracted, cleaned with soap and water just like the rest of his body, and the foreskin replaced. Make sure to rinse thoroughly before replacing the foreskin to avoid irritation.

CRYING & COLIC

While all babies cry every day, some babies have excessive crying that is unrelated to being wet, hungry or tired. Colic is a common condition in which babies cry or fuss excessively, generally in the evenings or late afternoon. Colic usually begins at about two weeks of age, peaks at about six weeks of age, and is generally much better by four months of age. While it is extremely disconcerting when your baby is crying, as it seems you can't do anything to soothe him or her, colic is not harmful. We think that colic is most likely due to infant temperament, neurological sensitivity, and immaturity and is a normal, temporary developmental stage in some infants rather than a true disorder.

Usually colic is completely unrelated to the diet, but you may consider

eliminating all dairy products from your diet if you are breast feeding. Milk protein intolerance is the most common cause of feeding intolerance, which can lead to crying. A good rule of thumb, however, is that colic tends to be exclusively in the late afternoon/evening/nights, whereas with milk protein intolerance, symptoms are sporadic through the day. If you choose to eliminate milk from your diet temporarily as a trial, make sure you intake enough calcium and vitamin D from other sources.

Smoking (never a good idea) and caffeine should be eliminated as well if your baby has colic. You may suspect that certain foods make the crying worse, so you may try eliminating them and see if you notice a difference in your baby's colic. Generally speaking, however, specific foods do not cause colic.

If your baby is formula-fed, temporarily changing to a different formula such as soy, Good Start, which is partially hydrolyzed, or elemental formulas such as Nutramigen, Alimentum or Pregestimil, may help. Again, most of the time through colic is not related to the mother's diet or formula choice, but the symptoms can be confusing at times. Be sure to discuss a change in formula with us before you actually make the change.

Based on our own personal and professional experience, we strongly recommend the techniques recommended in the book and video, The Happiest Baby on the Block by Dr. Harvey Karp. His theory of the "4th trimester" sits well with our understanding of the onset and resolution of colic. His techniques involving the "5 S's" to induce the calming reflex are extremely effective. Learn to swaddle your baby with the arms down as he suggests in the book and video. Additionally, turn the baby onto the side when held, gentle swinging and "shushing" work for the vast majority of our babies.

Additionally, you may find some of the following information, helpful during this difficult, but temporary, period.

1. Always remember colic is temporary. It will go away.
2. Try to find a helper to give you a 30-60 min. break several times a week during the crying period. Even short breaks can be extremely refreshing. NEVER shake your baby. Colic is maddening for parents because you feel

helpless in that you cannot stop your child's crying. Identify a person who can give you a respite when you are feeling frustrated.

3. Colic is not anyone's fault. It isn't inherited from one parent or another. It is never helpful to blame your spouse or mother-in-law, because they are frustrated with the baby's crying as well.

4. Simethicone (Mylicon) drops or Gripe Water are safe but probably not helpful for colic.

5. "Wear" your baby. Most infants cry less when they have been carried in a sling or other type of carrier for much of the day.

6. Motion can help. The "colic carry" is described as holding the baby prone on your arm and bouncing gently up and down or walking around the house. You may find that alternating between putting your baby in an infant swing, taking them for rides in the car, and placing them in a vibrating bouncer seat can help for brief periods.

7. "White noise" can help. Some babies respond to being placed next to a tumbling dryer or a running vacuum cleaner.

8. Try a pacifier.

9. Try to identify a source of pain. Is the diaper or the velcro tie chafing the baby? Is there swelling or pain of any area of the baby's body? Does he or she have a fever? Check rectal temp if you are not sure.

10. If you have tried everything you can think of to help your upset baby, including making sure that he or she is dry, fed and comfortable, it is perfectly fine to place the baby in his or her crib for five to ten minutes at a time and allow the baby to cry. Some studies show that 15-30 minutes of intense crying can actually reduce the duration of a colicky evening.

CONGESTION

Almost all babies get congested, whether from a cold or normal secretions. Stuffy noses are typically a bigger problem for the youngest babies because they do not know how to breathe with their mouths except when they cry. While their breathing may be noisy, congestion is really only a concern if your baby is having trouble eating or sleeping, or seems really uncomfortable because of the stuffy nose.

Use a bulb syringe to remove some of the secretions. To use, depress the bulb

with your thumb, then gently place into the nostril and release. Irrigation with saline drops may also be helpful in conjunction with bulb suctioning. Use a generous amount of normal saline (Little Noses, Ocean drops, etc.) in each nostril and then suction. This irrigates the nose and loosens secretions. Nasal suctioning is safe enough to do very frequently, but can cause bleeding from mild trauma to the nose. Therefore suction only when your baby is having trouble eating, sleeping or seems uncomfortable due to congestion, rather than when he or she is simply noisy.

A humidifier may help keep the nasal passage moist. If you use a humidifier, be sure to clean it out once a week according to the manufacturer's instructions. A vapor bath is not harmful and may be soothing to your baby. Stuffy noses are very common and may persist for several months in some cases. It is more important to note how a child is acting, rather than how loud he or she is.

Over the counter cold medications are NOT considered safe for any infant.

PLEASE CALL THE OFFICE IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS REGARDING YOUR BABY'S CONGESTION:

- Is the baby excessively sleepy, irritable or uninterested in feeding?
- Has the baby been fine for several days and now seems worse?
- Does the baby have a fever (>100.4 rectally)?
- Does the baby wake during sleep because of the congestion?
- Is the baby increasingly irritable?
- Is there coughing or is the baby working very hard to breathe?
- Is the baby not able to take the breast/bottle due to the congestion?

COUGH

Cough is a very common pediatric complaint. There are many causes for cough, and an occasional cough is a normal protective mechanism to clear the airways. Generally speaking, a cough should not be suppressed with medication, especially in infants. Children do not typically spit out the mucous they cough up. Parents worry that swallowing the mucous will hurt them, or let it "settle in their chest" but this is not the case.

PLEASE CALL THE OFFICE IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS REGARDING YOUR BABY'S COUGH:

- Is your baby under one month and has been frequently/forcefully coughing for more than a day?
- Is your child breathing faster or harder than usual?
- Do you hear any wheezing?
- Does the cough sound like a "barking seal" or "barking dog?"
- Has the child recently choked on something in his/her mouth?
- Is he/she acting ill?
- Has the cough been so forceful that it has led to vomiting?
- Has the cough lasted more than one week for a baby over one month old?

To manage a cough, remember to help the cough do its job of clearing the body of unwanted secretions. For infants, offer plenty of breast milk or formula, with an occasional ounce of water or Pedialyte to keep the baby hydrated and allow the secretions to be as thin as possible.

Over the counter cold medications are NOT considered safe for any infant and are discouraged except for rare instances.

DIAPER RASH

Nearly every baby gets a diaper rash at some point, but there are some easy ways to minimize the time a baby has a rash. Highly absorbent diapers can keep a baby drier, but it is still important to fully dry your baby's bottom before you replace the diaper. Fan the baby to fully dry the skin. If the skin is healthy, no cream or ointment is usually necessary. Baby powder and cornstarch are not helpful. If you see any redness or irritation at all, you may use petroleum jelly (Vaseline) or A&D Ointment. It is a good idea to avoid commercial baby wipes in the first few weeks, or to use them only when away from home to minimize skin irritation. When you use them, we find it useful to rinse them with warm water to reduce the exposure to irritants and to warm them for a more comfortable diaper change.

Diaper rashes generally come in two varieties: irritant and fungal (yeast). The irritant diaper rash can come from excessive wetness or an irritation

due to any material or chemical in the diaper. Simply changing brands may help if you have done your best to assure dryness. An irritant diaper rash usually responds to a cream with zinc oxide, such as Desitin or Dr. Smith's, and is usually found on the buttocks themselves, outside the folds of skin. A fungal/yeast rash typically has little red dots that spread out from inside folds of skin. You can try applying a bit of Lotrimin (Lotrimin or any generic brand is fine) cream each time you change the diaper for a yeast rash.

Often times it is difficult to tell the difference between irritant and yeast/fungal rashes. If you aren't sure, you can mix equal parts of a zinc oxide cream with Lotrimin. Mix together well and store in a disposable dish with a lid, then apply with each diaper change. If these interventions don't work, it is best to make an appointment.

FEEDING SCHEDULE & INTRODUCING SOLID FOODS

All parents long to have a full night of sleep and they look forward to the night they will again get eight hours of uninterrupted sleep. It is completely normal for a baby to wake every two to three hours for a feeding for several weeks to months, especially if breastfed. It might be helpful to remember that until birth, your baby was connected to a 24-hour infusion of nourishment, and will take some time to become accustomed to feeding less frequently. Additionally, their day/night rhythm is usually very different from ours, at least initially, and this may take some time to adjust.

On-demand feedings are recommended for the first few weeks of life, and then you can gradually develop a flexible schedule that allows you to have more of a routine. Your baby's needs will vary from day to day, however, so do not expect an exact feeding schedule. Remember to be flexible, as well, because growth spurts are your baby's way of increasing breast milk production and should be respected. These spurts last from one to three days and commonly occur at two weeks and six to eight weeks, then irregularly. If you try to stick with a schedule despite the baby's growth spurt, your milk supply will not increase to meet those increased demands.

The average breastfed baby will sleep through the night (six to eight hours) by six months of age. The average bottle-fed baby will sleep through the night by four months. Often it is difficult to determine if a baby is waking because of hunger or habit. Growth spurts can definitely disturb a routine that you thought was established, but usually only last a few days. Generally speaking, night feedings are no longer necessary for a bottle-fed baby by six months of age, and by eight months of age for a breast-fed baby.

We encourage you to gradually move your baby's sleep pattern toward more night sleeping by waking the baby every two to three hours for feedings during the day and allowing a newborn to sleep up to four to five hours at night if he or she is growing normally. During night feedings, provide as little stimulation as possible. For example, keep the lights low, don't play or talk very much, and change the diaper only if truly necessary. After three to four weeks of good growth and weight gain, you can allow your baby to sleep at night as long as they naturally can. Rigid scheduling of a baby, however (such using the "Babywise" method), has been shown to be dangerous and in some babies has lead to serious nutritional problems and even rare deaths. We encourage you to talk with us first before you decide to embark on any rigid feeding schedules.

The AAP recommends that you do not begin feeding your baby solid foods until four to six months of age. After your baby has mastered the spoon and is older than six months of age, you can begin fruits and vegetables in whichever order you prefer. Some mothers prefer to start vegetables first to avoid creating a sweet tooth, while others prefer to start fruits first since they are often more easily accepted. The choice is yours, and babies in general do well with either. We do ask that you wait five to seven days between introducing each new food to detect potential food allergies. Common food allergy reactions include diarrhea, rash and vomiting.

Foods to avoid during the first year include fish and shellfish (such as shrimp), eggs, peanuts and peanut butter, and honey. Fish, shrimp, eggs, and nuts are the among the most allergenic foods, so should be avoided until children are at least one year of age. Honey can contain botulism spores, which can be deadly to infants. Milk products such as yogurt and cheese can be introduced by nine months of age, but do not use cow's milk as a substitute for the more complete nutrition of breast milk or infant formula.

Recommendations for reducing the risk for food allergies change from time to time, and this is a dynamic area of research. Currently, there is no strong recommendation for delaying the introduction of allergenic foods (peanut butter, fish, eggs, etc.) any longer than 12 months of age, even in families with strong histories of food allergies. We would be happy to discuss this further at your next well child exam if you have further concerns or want the most recent information.

SOLID FOODS: *What* & *When*

Starting solid foods is certainly a milestone for your little one! With so much information available to parents from magazines, the internet, grandparents and friends, we thought we would give you a handout that will help establish a framework that you can use as your child begins to explore new foods.

In general you do not need to buy pre-prepared baby foods. We would encourage you to try to prepare baby foods from fresh fruits and vegetables whenever you can. Organic fruits and vegetables are becoming increasingly available, so use them if your budget allows. Please understand that we also appreciate that many busy parents can not prepare their own baby food, and we are grateful that quality pre-prepared baby foods are available as well.

Many books on the market are available to give you some guidance. Super Baby Food by Ruth Yaron, and others about grinding/blending your own foods are a great starting point for your own good ideas. We also recommend you do some basic reading on good child nutrition, and we would suggest the AAP Book, Guide to Your Child's Nutrition. Two foods should not be prepared at home, however. Infant cereal (i.e. Rice Cereal, etc.) should generally be purchased commercially because it is an essential source of iron in your infant's diet after 4-6 months, one that is very difficult to recreate accurately at home. Additionally, carrots can contain excess nitrates, so you might consider purchasing those instead of preparing your own.

In most cases solid foods should not be started before 4 months of age. The American Academy of Pediatrics recommends that infants be exclusively breastfed (or formula fed) until a minimum of 4 months of age, when solid

foods can be added. The following will provide a framework or general guidelines to keep you moving in the right direction. Items in bold will highlight the most critical information.

4-6 months

- *Single grain cereal once a day until well tolerated*
- *Mix like a watery oatmeal with breast milk, infant formula or water; consider diluted apple juice if the baby doesn't accept well*
- *Increase to twice daily after about a week, schedule as convenient for you*
- *If well tolerated, may add a new food (i.e. new grain of cereal or a fruit or vegetable) every 4-5 days*
- *Generally a sweet vegetable is a good start (i.e. sweet potato)*
- *Have fun. No pressure. Nothing is truly needed until 6 months.*
- *NO CITRUS, MEAT, DAIRY, EGG, FISH, NUT, HONEY*

6-9 months

- *Meals twice daily, increasing to three times daily by 9 months*
- *Cereal once or twice a day, adding texture as tolerated (i.e. less watery, more densely textured) especially while teething*
- *New fruit/veggie/grain every 4-5 days*
- *Hand foods (i.e. biter biscuits, zwieback toast) by about 7-8 mos.*
- *Finger foods (i.e. puffs, cheerios) by 8-9 months*
- *Advance texture as tolerated for choking/gagging, etc. for the individual child.*
  Some children can tolerate lumps and small chunks, others can't.
- *Breast milk (or formula feeding) is still the primary nutrition source, don't reduce the number of feedings yet. Give approx. 24-32 oz per day.*
- *Foods that cause a local reaction (i.e. diaper rash or mild mouth rash) can be tried again in 3-4 weeks. If a larger reaction is suspected, please ask us first about a re-trial.*
- *Avoid over-doing the orange vegetables to keep the skin from turning an orange hue.*
- *Start working on a sippy cup so we can eliminate bottles by 12 months. Start with just water for now.*
- *NO EGG, FISH, NUT, HONEY, CITRUS*

9-12 months

- *Continue to increase variety and texture as tolerated*
- *OK to introduce dairy (yogurt, cottage cheese, cheddar/American cheeses) Avoid string cheese or cheese soft cheese.*
- *OK to introduce meat (chicken, beef, turkey, etc)*
- *Egg Yolks are OK but avoid the whites*
- *May slowly introduce citrus as tolerated.*
- *Finger feeding & increasing independence should be encouraged, larger pieces of foods may be tolerated more easily.*
- *3 meals and 1-2 snacks per day, moving toward a toddler diet*
- *Begin slowly decreasing breast milk (or formula) and increase solids*
- *Approx. 20-24 oz. day of formula equivalent gradually decreases to about 12-16 ounces by 12 months*
- *Work on a sippy cup so we can eliminate bottles by 12 months*

- *Juice is never necessary, breast milk and water are adequate*
- *Any grain, fruit, vegetable are OK as tolerated*
- *NO FISH, NUT, HONEY, EGG WHITE*

12 months +

- *Toddler diet including 12-16 ounces of whole milk per day*
- *3 meals and 2 snacks*
- *Fish, nut, and egg white can be introduced unless FAMILY HISTORY OF FOOD ALLERGY, then wait until at least 2 years*
- *Continue to wait 4-5 days in between any new foods*
- *Juice and other sugary beverages should be a rare treat*
- *Heart-healthy diet and whole grains should be emphasized*
- *Exception: WHOLE MILK is truly needed for the 2nd year for brain growth*
- *Start playing with a spoon & fork about 14-15 months & allow the "mess" as often as you can tolerate*
- *Breast feed as long as you desire, but eliminate night feedings as early as possible for healthy teeth and ears*
- *Foods to be avoided are minimal, but be CAREFUL FOR FREQUENT CHOKING HAZARDS (i.e. raw vegetables especially raw carrots, chips and other foods that fragment, hot dogs and grapes that are not cut quite small, etc)*

DEVELOPMENTAL MILESTONES YOUR BABY'S FIRST YEAR

Every child develops at his or her own pace, but there are key milestones that we observe as your child develops. If you do not feel that your child is meeting the milestones listed below, please let your pediatrician know at your next well child visit.

We have included handouts from **www.zerotothree.com** which detail what infants from 0-12 months are expected to do at each stage, but also what you can do to foster their development further. An additional excellent resource, including an interactive developmental inventory can be found through the CDC website listed here: **http://www.cdc.gov/ncbddd/actearly/milestones/index.html**.

Birth to 3 Months

Your Baby's Development

The first 3 months are all about babies learning to feel comfortable, safe, and secure in the world. By responding to their signals and providing lots of love and comfort, you help them form a trusting bond with you.
How are you helping your baby learn to feel safe and secure?

What Your Baby Can Do	What You Can Do
I am getting to know you and the other people who love and care for me. • I recognize your faces, voices, and smells. • I respond to your smile and touch with pleasure.	**Talk and sing to your baby.** This makes him feel loved and helps him bond with you. **Hold your baby.** Enjoy some skin-to-skin cuddle time with your little one.
I am learning how to "tell" you what I need. • I can use my sounds, facial expressions, and body movements to tell you how I'm feeling—sleepy, hungry, happy, or uncomfortable. • I can show you when I want to play and when I need a break.	**Watch your baby to learn her signals.** Does she have a "hunger" cry? Does she rub her eyes or look away from you when she is tired? Smiles are easy to figure out. **Respond to your baby's signals.** When her eyes are bright and she is awake and alert, it is time to play. Slow things down when she cries, turns away, or arches her back.
I am beginning to use my body to make things happen. • I can grip your finger or a toy you put in my hand. • When I am hungry, I might move my head toward my mother's breast or the bottle.	**Give your baby something to reach for and hold onto—a finger or toy.** Let him touch objects with different textures and shapes. Hold a toy within your child's reach so he can swat it with his hands or feet. **Watch to see how your baby is "discovering" his body.** Does he look at his hands, suck on his feet, or try to roll?
We are becoming closer and closer every day. • I am learning to trust that you will read and respond to my signals. • I rely on you to comfort me. This helps me learn to comfort myself.	**Comfort your baby whenever she cries.** You can't spoil a baby. Soothing makes her feel safe, secure, and loved. **Help your baby calm herself** by guiding her fingers to her mouth, giving her a pacifier, or offering her a blanket or soft object that is special to her.

ZERO TO THREE
National Center for Infants, Toddlers, and Families

As you use this resource, remember that your child may develop skills faster or slower than indicated here and still be growing just fine. Talk with your child's health care provider or other trusted professional if you have questions.

Your family's cultural beliefs and values are also important factors that shape your child's development.

For more information on parenting and child development, go to: **www.zerotothree.org**.

3 to 6 Months

Your Baby's Development

This time is all about parents and babies falling in love. Most babies are eating and sleeping more regularly. They are also responding more actively to parents and caregivers. Over the next few months, you will begin learning about your baby's preferences—what he likes and dislikes, how she prefers to sleep, eat and play. ***What are you learning about your little one?***

What Your Baby Can Do	What You Can Do
I am learning to control my body. • I push myself up to see the people I love and the things that interest me. I roll to try to get closer to you or to an interesting toy or object. • I can sit with help and hold my head steady. • I may start to rock back and forth on my hands and knees to get ready to crawl so I can get moving and explore.	**Place your baby in different positions to help her develop new skills like rolling, creeping, and crawling.** • Make sure she gets time to play on both her back and stomach. • Help her sit with support. This allows her to explore in new ways. • Be sure she is always put to sleep on her back.
I use my hands and fingers to explore. • I reach for and grasp objects and toys. I explore them with my fingers, hands, and mouth to figure out what they can do.	**Offer your baby toys to explore** that have different shapes, sizes, textures, and sounds. Show him ways to use these objects by shaking, banging, pushing, and dropping.
I communicate by using sounds, actions, and facial expressions. • When you shake my rattle, I may smile and move my arms and legs to let you know I want to keep playing. • I can make a few different sounds in response to your sounds—babbles, coos, and gurgles.	**Watch and respond to your baby's signals.** *You are smiling—I think you like looking in the mirror. Do you want to look at yourself again?* **Have back-and-forth "conversations" with your baby.** When you reply to her babbles, she knows you care about what she is saying. This helps her learn to talk.
I am getting used to the world around me. • I may be starting to develop a more regular eating and sleeping schedule. • I am beginning to notice daily routines. When you turn the lights down, I am learning it is time for sleep.	**Create routines for your baby.** • Help him learn it's time for sleep by doing the same things in the same order each night, such as bath, books, feeding, and then a lullaby. • Make up a song that you sing as you are getting ready to feed your baby. Each time he hears it, he'll know milk is coming. This may calm him and also help him learn to wait.

6 to 9 Months

Your Baby's Development

This is a time of great fun for parents as they watch their babies become eager explorers who are thrilled to discover that they can make things happen. A 7-month-old knows, *When I smile, mommy smiles back!* A 9-month-old lifts her arms to tell her dad, *I want you to pick me up.*

How is your baby making things happen?

What Your Baby Can Do	What You Can Do
I am learning to think and solve problems. • When a toy drops to the floor, I look to see where it went. • I figure out how things work by copying what I see you and others do.	**Comment on what your baby does to make things happen.** *You used your voice to let me know you wanted me to keep playing peek-boo.* **Let your baby explore interesting objects—** like toys with buttons to push.
I can control my body. • I can pick up small objects using my thumb and other fingers. • I can sit on my own, which helps me explore in new ways. • I may crawl or scoot to get around. I might even pull up on furniture to stand.	**Begin letting your child practice picking up baby-safe foods like slices of banana,** if you'd like your child to learn to feed himself. **Give your baby time to move around on his own.** This builds muscle strength and coordination.
I am working hard to communicate with you. • I babble a lot. When someone talks to me, I make sounds back. • I use my voice to express feelings, like joy and anger. • I copy actions you make, like waving "bye-bye" and shaking my head "no-no."	**Use words to describe your baby's feelings:** *You are mad that Daddy took away the crayon. You can chew on this rattle instead.* **If your baby is looking at something, point at it and explain:** *That's a radio. It plays music.* **Copy your baby's sounds and actions.** If she waves, wave back and say *Hello!*
My personality is starting to show. • I may love to meet new people or need time to feel comfortable with someone I don't know yet. • I may like lots of sound and activity or I may prefer things to be more quiet and calm. • I may be very active or more interested in watching.	**Notice how your baby likes to play and explore.** Does she like to move or does she prefer to sit and watch the world around her? **See how your baby reacts to sounds, sights, and social activity.** What does she seem to enjoy? What does she seem to dislike or get overwhelmed by?

Your Baby's Development

Babies are becoming good communicators as they get closer to turning 1 year old. This makes it a delightful time for parents. Babies can use their actions and sounds to let loved ones know what they want, like handing a book to a parent so that she'll read it aloud. ***How does your baby "tell" you what he wants?***

What Your Baby Can Do	What You Can Do
I can understand more words than I can say. • I am starting to understand what you say to me. I can even follow simple directions like *Go get the ball.* • I tell you what I want with my sounds and body movements. I may say a word or two, like *mama*.	**Tell your baby what is happening and what you will do next:** *After your milk, it is time for a nap.* This helps her learn language. Routines also let her know what to expect. **Put your baby's sounds and actions into words.** *You are pushing your food away. I think you are telling me you are all done.* **Name things your baby looks at or points to:** *That's the moon. The moon comes out at night.*
I can creep and crawl. • I have found my own way of crawling—on my hands or knees, on my stomach, "crab crawling" by moving backwards and sideways, or even scooting on my bottom! • I walk while holding on to furniture or your hand. I may even start walking on my own.	**Give your baby lots of time and a safe place to practice new skills** like crawling and walking. **Make a "trail of toys" in a child-safe place in your house.** Line up several interesting objects (a wooden spoon, a plastic bowl, a brightly colored dishcloth) that your child can crawl to and explore.
I know that things still exist even though I can't see them—especially you! • I may cry when you leave because I know you are still out there somewhere and I want you to come back!	**Play hide-and-seek games.** This helps your baby learn that things that disappear also reappear. **Be sure to say good-bye to your baby.** Never sneak out. This builds his trust in you and helps him learn to deal with difficult feelings.
I love to do things over and over again. • This is how I practice and figure out how things work. • Repetition also helps build my memory.	**Help your child take the next step in her play.** If she is banging two blocks together, see if she'd like to try stacking them. **Offer your child a ball to toss, a rattle to shake, or a scarf to swing.** These activities help children learn how things work. They also build the muscles in their hands that will help them learn to write.

A SPECIAL NOTE ABOUT AUTISM

Many parents are specifically worried about autism: how can it be prevented, what are the earliest signs, and how can I intervene for my child if I am concerned. Some early signs of autism include:

- Not responding to his or her own name by 12 months of age
- Not showing a caregiver something new or interesting, or pointing to a distant object (a bird or airplane, something high on a shelf) by 14 months of age
- Not engaging in pretend play by 18 months of age
- Avoidance of eye contact after 3-4 months of age
- Delayed language and speech
- Unusual or rejecting responses to cuddling or physical affection

Another excellent resource for identifying the early signs of autism can be found through the CDC at **http://www.cdc.gov/ncbddd/autism/signs.html.**

FEVER AND HOW TO TAKE YOUR BABY'S TEMPERATURE

A fever is defined as a temperature greater than 100.4 rectally. Fever in an infant under two to three months of age should always be considered an urgent concern, prompting a call or visit to our office. If the office is closed, we would like you to call us immediately and we will likely send you to an emergency room for an evaluation. After three months of age, we are less concerned about fever because the baby's immune system is better developed. We are usually not concerned about the temperature itself, but rather the underlying illness that is causing the fever. It is often difficult, if not impossible, to tell the difference between a viral illness and a bacterial infection, especially in a young baby. Therefore, an evaluation by a doctor is necessary for all babies with fever until the baby is at least three months of age. After three to four months of age, we can make evaluations by judging the baby's behavior, feeding, and other cues, and often this can be done by phone. In any case, we expect you to call us and together, we can develop a plan.

In very young infants, a low temperature can be as dangerous as a fever. If your baby is excessively fussy or sleepy or you are concerned that the baby's

behavior has changed significantly, take the temperature as a screen. If the temperature is greater than 100.4 or lower than 97.0, please let our office know immediately.

Please never give Acetaminophen (Tylenol) or Ibuprofen (Motrin or Advil) to a baby under three months of age without a doctor's permission, as this can mask a fever and therefore mask a potentially serious infection.

The most accurate and least expensive thermometer is the old-fashioned glass thermometer; they are no longer made with mercury. A digital one can also be used. Ear-scan thermometers and pacifier-type thermometers are notoriously inaccurate in babies, but the forehead (temporal artery) scanners are more accurate. You can take a temperature under the arm as an initial screen, but it is not considered accurate for a small baby. Taking a rectal temperature is more accurate. When you tell us about a temperature, don't add a degree for a underarm (auxiliary) temperature. Tell us the number and how you took the temperature.

To take a rectal temperature, first wash and rinse the thermometer and shake it until it is reading below 96 degrees Fahrenheit. Next, rub a small amount of lubricant such Vaseline or KY Jelly on its tip. While your baby is lying down on your lap, hold one of your hands firmly on his lower back, just above his buttocks. Gently insert the thermometer into his rectum about one-half to one inch. Wait for two minutes (or until it beeps if using a digital) and then remove the thermometer. For glass thermometers, roll the thermometer until you see the fluid column and read the temperature at the end of the column.

Keep your baby away from sick people as much as possible. Encourage visitors to wait a few more days if they have a cold, and minimize outings to brief trips when you can. Visitors should wash their hands before holding your baby, and wash your own hands often. If visitors feel you're going overboard or are germ-phobic, just blame it on us. We don't mind.

Feel free to take your baby outside, take brief trips to the store and visit eager family and friends, but try to be cautious. We don't recommend air travel before 6-8 weeks of age, especially until we can get at least that first

set of vaccines done. We feel it is always better to prevent a febrile illness in a baby than to have to worry over a sick baby, especially since we know that most babies under 2-3 months of age with fever will end up in the hospital for a few days.

FEVER REDUCERS: ACETAMINOPHEN AND IBUPROFEN

Never give Acetaminophen (Tylenol) or Ibuprofen (Motrin or Advil) to a baby under three months of age without a doctor's permission. This can mask a fever and therefore mask a potentially serious infection. **If your child has a fever >104 at any time, please contact us.**

If your child is over three months old or you have received permission from a doctor to use a fever reducer, the following chart may help you. Additionally, we will update you on exactly how much your child needs according to weight at each well child visit. Remember that we don't recommend Ibuprofen until about six months of age. Combination medications (i.e. multi-symptom cold remedies) are not recommended for infants at any time as the cold medications are not considered safe. Additionally, if you give a combination medication plus a fever reducer, you may be duplicating, and therefore overdosing, the fever reducer. Also, be careful to read the bottle carefully. Infant drops are concentrated so less volume is necessary for little babies, so be careful to give the right amount. For example a "half teaspoon" of infant drops is actually equivalent to a full teaspoon of the elixir preparation.

We hope this chart will help you determine how to dose your child with fever-reducers, no matter what form you have available.

ACETAMINOPHEN

Weight	Infant's Drops	Tablets or Chewables 80mg	Children's Elixr 160MG/TSP
6-11 lbs	1/2 drp. (0.4ml)	n/a	n/a
12-17 lbs	1 dpr. (0.8ml)	n/a	1/2 tsp.
18-23 lbs	1 1/2 dpr. (1.2ml)	n/a	3/4 tsp.
24-35 lbs	2 dprs.	2 tab	1 tsp.

IBUPROFEN

Weight	Infant Advil Concentrated Drops 50mg/1.25 ml	Children's Advil Suspension 100mg/5ml	Children's Advil Tablets 50mg/tablet
12-17 lbs	1.25 ml	1/2 tsp.	n/a
18-23 lbs	1.875 ml	3/4 tsp.	n/a
24-35 lbs	n/a	1 tsp.	2 tablets

IMMUNIZATION SCHEDULE

The vaccine schedule will vary from time to time, but this will serve as a good starting point. Typically we give vaccines at 2, 4, 6, 12, 15 and 18 months. Catch up vaccines are given, as needed, at 9 and 24 months of age. Our goal is to have the primary series completed by 2 years of age.

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	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			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR		*see footnote 7*			MMR
Varicella[8]						Varicella		*see footnote 8*			Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV	

Range of recommended ages

Certain high-risk groups

JAUNDICE

All babies become slightly jaundiced a few days after birth, but most babies require no therapy at all. Jaundice is caused by one of the many changes that occur in the baby's body after birth. The yellow color generally begins on the face and progresses downward as the level increases. The most important remedy for jaundice is frequent feedings, which leads to lots of bowel movements, eliminating the pigment (bilirubin) that causes the yellow color. Basking in the sunlight through a bright interior window is another way to help decrease the yellow color. Brief periods of direct sunlight outside may also be helpful. The sunlight changes the bilirubin into a form that can be removed in the urine. The peak level for breastfed babies is generally about four to five days, and for bottle fed babies, about three to four days.

Babies are at higher risk for jaundice if their mother has Type O blood, if they have siblings with a history of jaundice, and if they experienced significant bruising during delivery. However, any baby can become significantly jaundiced.

For babies who have a dangerous level of jaundice, special lights may be used to help eliminate bilirubin faster and keep it from getting to a dangerous level. Usually, this happens in a hospital setting – either before the baby is discharged from birth, but occasionally with a readmission if the jaundice came on a few days later. If kept unchecked, jaundice can lead to brain damage. This is certainly a rare event, but working together, we can keep this from becoming an issue.

If your baby's yellow color is limited to the face and upper shoulders, you do not need to seek attention. However, if the jaundice is below the shoulders and the baby is not feeding well, or has persistently black or green stools after four or five days, please let us know. A blood test can help us determine if your baby needs some help to relieve the jaundice. Very rarely, a high level of jaundice can be dangerous to the baby's developing nervous system, so we do want to be careful.

Some breastfed babies have jaundice that lasts somewhat longer than average. If breast feeding is going very well and the baby is growing nicely, we generally do not need to intervene. A blood test is sometimes done to follow the level of jaundice. If it persists, we will occasionally temporarily stop the breast feeding then restart after about 18-24 hours. If you are concerned, please let us know.

NEWBORN BEHAVIOR

Newborns do some strange things that worry parents. Many of these behaviors are normal and are just signs of an immature nervous system. Others are just normal adjustments to living outside of the mother's body. Most will gradually fade and will be gone by four to six months.

- Quivering of the chin or lower lip
- Hiccupping
- Sneezing
- Irregular breathing
- Passing large quantities of gas
- Spitting up or impressive belching
- Making noises during breathing or sleeping and moving around
- Easily startled (called the Moro Reflex and is a sensation of falling). This is generally relieved by bringing the arms to the midline or bringing the hands to the side of the body as in a swaddle.
- Straining with bowel movements
- Gurgling sounds in the throat or growling and being noisy during sleep
- Jitteriness or trembling, occasionally with twitching of the body. If these are not rhythmic and are easily stopped by gently touching the jittery body part or are relieved by sucking, there is no need to worry. If they don't stop with these maneuvers, please call us immediately.
- Frequent yawning
- Eyes crossing temporarily – usually better by 2-4 months of age

PACIFIERS

Pacifiers are not necessary for every baby, but many babies have a higher need to suck than others. If your baby is frequently sucking on the fingers or thumbs, or if your baby seems to be using the breast as a soother too often, you might consider using a pacifier. Interestingly, the use of pacifiers seems to be a factor that reduces the risk of Sudden Infant Death Syndrome (SIDS). More information on SIDS is found later in this book.

If breast feeding is well established, the pacifier will not interfere with breast feeding. We feel that pacifiers are a better alternative to thumb sucking because the pacifier can be easily removed later. Obviously the thumbs can't. We have no preference as to what type of pacifier your baby takes, although silicone is preferred over latex.

Parents often worry about how they will get rid of the pacifier when the child is older. Once a child is starting to use language, we recommend that you limit the pacifier to bed/nap time or stressful events such as a doctor's visit or very long car ride. Dentists generally recommend that the pacifier is removed by the second or third birthday, but if there is a risk that the child will quickly switch to a thumb or fingers, you will want to wait a little longer. If you experience a period of time that the child is using the pacifier less, not asking for it or seeking it, take the opportunity to remove the pacifier at this time. Certainly we would like to see the pacifier gone by age 3 years; if you are having a difficult time in eliminating the pacifier by 3 years, we can talk about it at a well check.

RASHES

Many newborns and young infants get rashes frequently as their skin adjusts to conditions outside of the womb. Most newborns have dry skin, and lotions or baby oil are not necessary. In fact, sometimes baby oil or lotion can cause further problems, make the dry skin last a longer time or irritate sensitive skin. Most rashes are normal but unfortunately they are difficult to accurately diagnose over the phone, and will most likely need to be seen to be properly diagnosed.

WE WILL ASK TO SEE YOUR BABY IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS REGARDING YOUR BABY'S RASH:

- Are there any fluid-filled blisters?
- Is your baby's temperature greater than 100.4?
- Is the child acting sick or less active/alert than usual?
- Does the rash seem to bother your child?
- Do you see any scabs or extremely irritated areas?
- Does the area with the rash feel warmer than the rest of the skin?
- Is the baby on any medication?

If the answers are all "no," you may observe for a few days and make a routine appointment if you are still concerned. For further information on skin care and mild rashes, see the "Bathing & Skin Care" section.

SIDS PREVENTION AND SLEEPING POSITION

SIDS, or Sudden Infant Death Syndrome, remains a medical mystery. Although we do not understand why this occurs, we do know that there are ways to increase or decrease the risk of this happening to your child. Interestingly, home monitors (apnea alarms) have never been shown to decrease the risk of SIDS, even for the most vulnerable babies. Here are some tips that we know can modify your baby's risk of SIDS.

Sleep Position

- *Place your baby on his or her back for sleep, including naps and overnight. Side and tummy positions are not safe.*

Mattress

- *The mattress should be firm and safety-approved. Never place the baby on pillows, quilts, sheepskins or other soft surfaces. Keep soft objects such as stuffed animals and toys out of the sleep area. Bumper pads are NOT recommended.*

Bed Sharing

- *Babies are safest in your room, but not in your bed. We recommend that your infant sleep in your room until 4 months of age.*

Breast feeding

- *Breast feeding clearly reduces the risk of SIDS*

Temperature & Air Flow

- *Dress your baby in light sleep clothing and keep the air temperature comfortable, not warm.*
- *A fan in the room to circulate air may decrease the risk of SIDS.*

Pacifiers

- *Do not force this, but use of a pacifier may decrease the risk. We advise waiting until your breast feeding is well established to introduce a pacifier.*

Sleep Positioners

- *Products that claim to reduce the risk of SIDS are very unlikely to be tested for effectiveness or safety. We can not recommend them as there is no data to support their use.*

Share This Information

- *Not all caregivers, including loving nannies, grandparents, aunts/uncles and baby sitters are aware of the latest information. Make sure that anyone caring for your infant puts your baby to sleep on their back.*

Some Great Resources:

http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf
http://www.aap.org/healthychildren/09s_bts/SIDS.pdf

SUNSCREENS & INSECT REPELLENTS

We are blessed with many sunny days here in the Austin area. While parents want to give their children the benefit of fresh air and sunshine, we do need to take precautions to avoid excessive sun exposure to the tender skin of infants and young children. Besides causing the discomfort of sunburn, development of most skin cancers can be directly linked to excessive sun exposure in childhood and adolescence.

The best way to minimize excess sun exposure is by covering up with clothing, and staying under cover, and avoiding direct sun. Dress your infant in loose, light-colored clothing that covers the majority of the skin, and a hat. Avoid the peak hours of sun intensity, from 11 am – 5 pm if at all possible. We usually don't recommend a sunscreen for infants under 6 months because their skin is so sensitive. However, if sun exposure is

unavoidable, use a sunscreen designed for children, with a SPF of 30 or higher. Try a test patch on the baby's back a few days before you need to use it to ensure that there is no sensitivity. Use sunscreen only on exposed areas, taking special care around the eyes. Sunscreen should be applied 15-30 minutes before sun exposure and reapplied every few hours, as well as after water activities.

As children get older, we know that some sun exposure is very healthy and allows their body to activate Vitamin D for healthy bones. We believe that 15-20 minutes of sun exposure (without sunscreen) per day is adequate after 6-12 months of age. This area of research is in a very dynamic phase right now and we expect further information soon.

Fortunately, insect-borne illness is rare in infants and children, but we do want you to be aware of how to minimize the risk. DEET and Picaridin are the two most effective insect repellents on the market. Both are available in commonly available commercial products. Never use insect repellents in infants under 2-3 months of age. We recommend you choose the lowest concentration that you need. For most children, DEET 10% should be adequate coverage for 2 hours of protection. Try to avoid using a higher concentration. Deet should not be reapplied after use, but Picaridin can be reapplied several times per day.

Apply to exposed areas but do try to avoid the hands on small children, who naturally put their hands in their mouths. Avoid using around the mouth and never use over cuts, wounds or irritated skin. Don't use DEET around food, and apply the product outside. After you come back inside, wash exposed skin and change/wash clothes.

Two more important words of advice: Never use a combination sunscreen/insect repellents. Because sunscreens need to be repeatedly reapplied and DEET-containing insect repellent should be used only once daily, we recommend that you use separate products. Also, brightly colored clothing, floral prints, and perfumes attract stinging insects, so avoid these if possible.

TEAR DUCT BLOCKAGE

A very common problem we see in newborns is a plugged or blocked nasolacrimal duct (tear duct). The tear duct starts at the inside of the lower eyelid and drains tears into the nose. The drainage system isn't completely operational in some babies, caused by a partially collapsed or sticky nasolacrimal duct. Tears can back up, like a clogged stream. The water in the tears evaporates, leaving protein and salts behind to make it crusty and mucousy. This rarely becomes infected, but it can certainly look like conjunctivitis, or "pink eye."

Massaging the lacrimal sac, the area just below the duct opening (the inner lower corner of the eye) may help open up the duct. Wash hands first, then gently massage the area with a upward or downward or circular movement before each diaper change. You may see a small amount of fluid emerge from the lacrimal duct.

The vast majority of cases resolve on their own by nine to twelve months of age. If not fully resolved, we will refer you to a Pediatric Ophthalmologist for further evaluation.

Although true infection is uncommon, if the area appears to have a thick green discharge, we may prescribe an antibiotic. Please call us if the area appears increasingly red, is warm to touch, is associated with a fever, or suddenly worsens.

TEETHING

Teething symptoms such as drooling, chewing on objects, and fussiness can occur for weeks to months before you ever see a tooth emerge. A lot of behavior and fussiness is blamed on teething, especially because it's difficult to tell what's going on under the gums. Topical analgesics such as Orajel and Anbesol are generally not very effective and work very temporarily. If you think your baby is truly uncomfortable, consider a dose of Tylenol (after 2 months of age) rather than a topical agent, as it can last up to 4 hrs, rather than a few minutes with a topical anesthetic. Give your child plenty of teethers to chew on. Frozen or chilled teethers and toys can be very helpful as well. A moist/frozen washcloth can be a great teether.

The average first eruption of teeth occurs when your baby is approximately six months old, but we can see teeth as early as two months. Some babies have a full mouth full of teeth at 12 months, while others have none. Generally the first teeth are the bottom central incisors (bottom front), followed by the top central incisors. If you are concerned about the timing or order of teeth eruption, talk with us at your next well-child check up.

A note on "teething tablets"

We do not suggest that you use homeopathic remedies such as "teething tablets." Their effectiveness is doubtful, and many contain belladonna, an extremely toxic plant-based (therefore "natural") chemical that can cause hallucinations at high doses. As homeopathic remedies are not subject to the same rigorous testing and inspection as are over-the-counter or prescription drugs, we simply would prefer to err on the side of caution.

UMBILICAL CORD CARE

The umbilical cord gradually detaches, and usually falls off by the time your baby is about two weeks of age. Do your best to keep the cord dry. While you don't need to routinely use alcohol to clean the cord, you can periodically clean it when you notice some discharge (brown, red) as the cord begins to fall away. Cleaning approximately 1-2 times per day is usually plenty, but be sure to get at the base of the cord where the discharge begins.

Keep the diaper folded down away from the cord and avoid a full bath until the cord is off and stops draining. Limit bathing to a sponge bath every few days until the cord is completely off and discharge is minimal. Immersion in bath water can lead to infection and delays the cord falling off.

You may see a small amount of reddish (even slightly blood-colored) or brown discharge from the belly button for a few days after the cord falls off, and this is normal. This discharge may increase as the cord begins to detach.

If there is significant odor or redness to the skin surrounding the cord/belly button, please call us immediately. Call us if your baby's cord is still firmly attached at four weeks of age.

VACCINATION POLICY AND PHILOSOPHY

As your partners for your child's health, we always do our best to collaborate with you in making decisions for your child. One of the most important health advances in the history of medicine is the development of vaccines. Vaccines have clearly had a positive impact in disease prevention, preventing millions of deaths worldwide.

At Southwest Pediatrics, we strongly recommend that you choose to vaccinate your child. We all agree that, while vaccines are never fun and always a little uncomfortable, they are an excellent choice for your child's good health and well being. Parents can be concerned about vaccines for a number of reasons, including concerns about their child's comfort, or about vaccine safety or effectiveness. Some parents wonder if vaccines are really necessary anymore because the diseases they prevent are getting less common.

Although mild side effects are common, they are indeed mild. Most children have little to no reaction. We will always give you an information sheet on every vaccine your child receives. And though the diseases we prevent with the vaccines are becoming less common, they still occur, even in our community. Every year children in the United States die of chicken pox, whooping cough and other vaccine-preventable diseases. We live in an increasingly global community, and diseases we rarely see can be brought from foreign countries, and not all of them exotic or underdeveloped. Recently, a measles outbreak was started when an unvaccinated child brought measles back from Western Europe.

We keep the diseases uncommon by vaccinating as many children as possible. Vaccines currently available for infants and young children do not contain any mercury-containing preservative (thimerisal). We also use as many combination vaccines as possible to minimize the physical discomfort associated with injections.

We always encourage you to read and study information available to you about raising a healthy child. Unfortunately, some information that you might read or see can alarm you unnecessarily. Immunizations have gotten some bad press in the national media. For years now, reports surface now

and again linking vaccines and various diseases or conditions. Despite these reports, there have never been any consistent or reliable data that support these claims. On the other hand, we have consistently good data support vaccine safety and effectiveness in preventing disease.

If you choose to not vaccinate your child despite our recommendation, we will ask you to sign a release form each time you are offered vaccines. We never want you to feel forced into doing anything that you do not want to do, but we do want you to understand the importance of this issue, and how seriously we take it.

The following are some websites that other parents have found useful when seeking objective and fair information about vaccines. We encourage you to explore these websites. Many of your questions will be answered here, but we would be happy to talk with you further if you have additional concerns.

www.cdc.gov/nip
www.vaccine.org
www.immunizationinfo.org
www.vaccine.chop.edu
www.aap.org

A special note on Vaccines & Autism…

There are very few subjects that bring about such anxiety and frustration than the accused link between vaccines and autism. This subject could be the topic of hours of discussion and yet we are left with skeptical families and families that are simply trying to do the right thing for their child(ren). We are open to your questions and would love to address them individually, but we hope that this section will answer many of these questions.

We wish to be clear:
We do not believe that vaccines cause autism.

There is no doubt that the rate of diagnosis of autism has risen dramatically over the last few decades. While we certainly do not have all the answers to why this has happened, we can state the following truths:

1) We are looking for autism in a much more aggressive way, leading to a new, large group of children with milder autism spectrum disorders. We know that early intervention is powerful, and we are actively looking for children who might need help at a much younger age than they would have had previously. Medical school graduates are getting the education they need and physicians in practice are learning to identify these conditions better.
2) More severe forms of autism become more obvious in most children at the age when they are receiving certain vaccines (i.e. MMR). Unfortunately, many parents confuse this coincidence as the "cause" and their stories seem very compelling and frightening.
3) Splitting vaccines into their component parts (i.e measles only instead of MMR) does NOT reduce the rate of autism. Combination vaccines reduce the pain and discomfort of multiple injections and we prefer them because they make your child suffer less. Shots hurt.
4) There is no known link between autism and the vaccine components or the compounds that make the vaccines germ-free or more effective. Specifically, there is no link between thimerisal (mercury-containing preservative) or aluminum (an element that makes the vaccine induce immunity) and autism. It is worth

noting that autism rates continued to rise at virtually the same rate when thimerisal was removed from the vaccine supply. There is simply not a connection.

5) Using an alternative schedule (i.e. going slow) does not reduce your child's risk for autism, but rather increases your child's risk to disease. Going slow also increases risk to your neighbor's children, your child's playmates and younger family members to disease. Some of these children are too young to receive vaccines. Some are too ill (i.e. cancer patients or those with immune deficiencies).
6) Using an alternative schedule will likely cause you to have more frequent visits to our office and most likely cause more out-of-pocket expenses.

With this being said, we honestly do welcome your questions. We also would prefer to have your child vaccinated at a slower pace than not at all. A relationship of trust and mutual respect is absolutely critical to the best care of your child, and we understand that we may have to respectfully disagree with your choices, just as you may have to respectfully disagree with our recommendations.

If, after all your own research, you have decided to vaccinate your child via an alternative schedule, we ask that you provide us with a written copy of the schedule you will use to facilitate the nurse visits and keep our communication as clear as possible.

VITAMINS

Most infants do not need a multivitamin. Special circumstances, such as when a baby was born prematurely or had complications, may warrant vitamin supplementation. We will work that out on a case-by-case basis.

Generally, breast milk contains all the nutrition your baby needs and multivitamins are not necessary. Recently, however, a new recommendation has been made for exclusively breastfed babies to receive daily supplementation of Vitamin D to reduce the incidence of rickets. Prenatal vitamins taken by the breastfeeding mother are not adequate to provide the recommended vitamin dose. If you are feeding your baby at least 12 ounces of infant formula per day, your baby is receiving adequate Vitamin D and no additional vitamin supplementation is necessary. Exclusively breastfed babies, and babies who receive less than 12 ounces of formula per day, however, should receive extra Vitamin D.

Vitamin drops are commercially available over-the-counter at most grocery stores and pharmacies. Multivitamins such as Polyvisol and Trivisol are readily available, but are actually more complete than your baby needs and taste pretty bad. More recently, Vitamin D-only drops have become available, but may be a little more difficult to find. Products such D-Vi-sol and "Just D" are now available but might require a little more searching. Exclusively breastfed babies need 400 IU of Vitamin D per day.

Fluoride is an important dietary supplement, which reduces the risk of cavities in your child's teeth. We recommend that you use fluoridated water for supplemental water or for mixing with formula. Tap water from a fluoridated municipal source (such as the City of Austin) or bottled "nursery water" is suggested. Certain municipalities do not fluoridate their water supply, and we know of one that is actually over-fluoridated and is NOT recommended to drink. Please check with your water supplier to see if their product is fluoridated. Ideally the level should be one ppm. If your research shows your child is receiving inadequate supplementation through the water supply, we can prescribe fluoride drops at six months of age.

If you utilize a reverse-osmosis water filtration system, you may have inadequate fluoride as well, so check with the manufacturer.

VOMITING AND DIARRHEA

We certainly worry about a small infant who is vomiting or has diarrhea. However, most babies spit up quite frequently and normal infant stool is quite loose and watery, so occasionally it is confusing to parents. Is it normal or a sign of illness? Continue offering breast milk or formula as is your typical routine unless you are directed otherwise. Sometimes offering smaller, more frequent feedings is helpful to minimize vomiting.

PLEASE CALL OUR OFFICE IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS REGARDING YOUR BABY'S VOMITING OR DIARRHEA:

- Is vomiting associated with increased irritability or excessive sleepiness?
- Is the vomiting extremely forceful (i.e. projectile?)
- Is the child's intake significantly less than usual?
- Does the vomiting occur more than one to two hours after a feeding?
- Is there any green, red or dark brown in the material vomited?
- Does the baby seem to be in pain or have fever greater than 100.4?
- Has the urine output decreased to less than four wet diapers per day?
- Is there any blood or mucous in the stool?
- Is the stool purely water consistency?
- Has the stool frequency increased to more than eight to ten per day?
- Is the baby's belly distended, firm or tender to touch?
- Does the stool have a very foul-smelling odor?

If you answer "yes" to any of the above questions, please call our office immediately for further information and instruction. Older children can be safely managed at home with oral re-hydration solutions, but infants require closer observation.

RECOMMENDED READING

If you are like most people, you probably have bookshelves filled with cookbooks, travel guides and novels. We feel that you should invest some time in reading about the most important job you will ever have: being a parent. Parenting style is very individual, however, so don't be alarmed by conflicting advice. Read a variety of books and magazines, but incorporate what feels right for your family. The following are books that have either been beneficial for us personally, or are highly recommended by the American Academy of Pediatrics. The AAP Press books can be found at www.aap.org and at most book stores and online booksellers.

THE HAPPIEST BABY ON THE BLOCK

by Harvey Karp

Essential for families with fussier babies, the book and video show you how to calm your fussy baby reliably and confidently. Strongly recommended. His follow-up book, The Happiest Toddler on the Block is also quite good.

BABY 411: CLEAR ANSWERS AND SMART ADVICE FOR YOUR BABY'S FIRST YEAR

by Ari Brown, Denise Fields

The authors cover a wealth of topics, including what to ask at a prenatal visit, accurate vaccine information and antibiotic resistance, the latest American Academy of Pediatrics guidelines, circumcision, secrets of sleep, autism, and more. The follow-up book, Toddler 411, is also very helpful.

WHAT TO EXPECT THE FIRST YEAR

by Eisenberg, Murkhoff and Hathaway

A very reassuring book that is in the same vein as the popular pregnancy book.

TOUCHPOINTS

by T. Berry Brazelton

A wonderful book on normal child development by an emeritus scholar and beloved pediatrician. "Touchpoints" are developmental phases that

can cause behavioral difficulties. Strong emphasis on how temperament affects your child's behavior and common-sense advice for the first few years in many areas.

PARENTING THE STRONG-WILLED CHILD

by Rex Forehand, PhD

An excellent book on common behavioral problems with children who have difficult temperaments. Very good, step-by-step plan for frustrated parents.

GUIDE TO YOUR CHILD'S SYMPTOMS

(AAP Press)

From the AAP website: "Guide to Your Child's Symptoms" is the complete home reference for all those who are concerned with the health of children. Offering parents the reliability and expertise of the country's most respected authority in child health, this guide is presented in a format that's easy to use in any circumstance, be it an everyday problem or an emergency.

YOUR BABY'S FIRST YEAR

(AAP Press)

From the AAP website: "Your Baby's First Year" offers state-of-the-art advice from the American Academy of Pediatrics. This text provides comprehensive, accurate, and up-to-date guidance on all aspects of infant care. Addresses medical questions, parenting concerns, safety issues, and more - all in an easy-to-use format. Information offered includes a month-to-month guide of a baby's first year in terms of growth, behavior, and development; a complete health encyclopedia; detailed instructions for coping with emergencies; schedules for immunizations and screening tests; recommendations on choosing child care; safety checks for the home, car; and much more!

GUIDE TO YOUR CHILD'S SLEEP

(AAP Press)

From the AAP website: While there are many books available on children's sleep, no single, impartial source has examined the conflicting theories,

until now. To help navigate the confusing information, "Guide to Your Child's Sleep" explores the different approaches (such as the "cry it out" and "family bed" theories), enabling parents to make the best decisions for their families.

LAST STRAW STRATEGIES

by Michelle Kennedy

This is a series of books on a variety of topics including sleeping, tantrums, eating, etc. with common sense strategies to everyday problems; very easy to read and practical.

CONFIDENT PARENTS, REMARKABLE KIDS

by Bonnie Harris, MS Ed.

Excellent book on principles of parenting throughout the continuum of parenting.

RAISING YOUR SPIRITED CHILD

by Mary Sheedy Kurchinka

A book on temperament and guide to parenting a child who is more intense, sensitive, perceptive, persistent, energetic than the average child.

A MIND AT A TIME

by Mel Levin, MD

America's top learning expert shows how every child can succeed.

THE HOLISTIC PEDIATRICIAN

by Kathi Kemper, MD MPH

A Pediatrician's comprehensive guide to safe and effective therapies for the 25 most common ailments of children, including alternative therapies.

NOTES