DMC
PRIMARY CARE

DMCPrimaryCare.com
603-537-1300

PARENTING GUIDE

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Welcome to DMC Primary Care!

We consider the opportunity to provide healthcare for your child a privilege, and we appreciate you placing your trust in us.

We have assembled this booklet, which contains advice and guidelines on some of the more common childhood illnesses, injuries and conditions you will encounter as a parent.

There are references at the end of this booklet (recommended reading) if you desire in-depth information about specific childhood issues. We recommend that you consult this booklet to assist you when caring for your child during a time of illness.

If you are uncertain how to care for your child after reading these guidelines or your child's condition is worsening despite following these instructions, please call the office for further instruction.

Raising children has become more complex due to the many stresses of life in the 21st century. Parenting is one of the most challenging responsibilities of your life. We encourage you to constantly build on your natural parenting instincts by reading, observing and asking questions of others.

We wish you and your family the best of health. Good luck on your journey through parenthood. We hope you laugh frequently, hug liberally and love always. Enjoy your most precious gift, your child. Children are truly our tomorrow.

Dennis G. Rork, M.D.

ACKNOWLEDGMENTS

The major written resource of information for this booklet was adapted from: **The Children's Hospital Guide to Your Child's Health and Development** and **Pediatric Patient Education from the American Academy of Pediatrics.**

Medical facts, charts and medical advice from these sources were transcribed outright or adapted in order to fit the format of this booklet.

DISCLAIMER

The information contained in this booklet should not be used as a substitute for the medical care and advice of your provider at DMC Primary Care. There may be variations in treatment that your provider may recommend based on individual facts and circumstances. Information applies to all sexes and genders; however, for easier reading, pronouns such as "he" are used throughout this publication.

HOW TO USE THIS BOOKLET

This booklet is only a quick guide to common childhood illnesses and injuries. Use the Table of Contents on the following page of this booklet to find the location/page of the desired medical topic. A short summary of the topic will be given, as well as treatment advice.

Under each medical topic, treatment recommendations are listed under three headings, depending on the urgency of treatment for your child's illness or injury. The three headings are listed as follows:

1. **Call for Emergency Help If:**
   The symptoms listed here are life-threatening; if your child is experiencing them, you should call 911 or call an ambulance to provide emergency services for your child.

2. **Call the Doctor Immediately If:**
   The symptoms listed here may require immediate evaluation and treatment. You should call the office immediately and ask to speak with the triage nurse. If the office is closed, you should call the answering service immediately and tell them it is urgent. The doctor on call will return your phone call as soon as possible.

3. **Call the Doctor Today If:**
   The symptoms listed here require you to contact the office during regular office hours to schedule an appointment for your child or, if needed, discuss your child's symptoms with our triage nurse.

**If you feel uneasy or uncomfortable caring for your child's illness or injury after reading this booklet, please call the office or the doctor on call for further advice at 603-537-1300.*

LIST OF OFFICE HOURS:

BEDFORD
Mon–Thurs 8:00 AM – 8:00 PM;
Fri 8:00 AM – 5:00 PM;
Sat 8:00 AM – 3:00 PM

CONCORD
Mon, Wed 8:00 AM – 8:00 PM;
Tues, Thurs, Fri 8:00 AM – 5:00 PM

DERRY
Mon–Thurs 8:00 AM – 8:00 PM;
Fri 8:00 AM – 5:00 PM

GOFFSTOWN
Mon, Wed, Thurs 8:00 AM – 8:00 PM;
Tues, Fri 8:00 AM – 5:00 PM

LONDONDERRY
Mon–Wed 8:00 AM – 8:00 PM;
Thurs–Fri 8:00 AM – 5:00 PM;
Sat 8:00 AM – 3:00 PM
This location also has Walk-In Care for DMC patients

RAYMOND
Mon, Tues, Thurs 8:00 AM – 8:00 PM;
Wed, Fri 8:00 AM – 5:00 PM;

WINDHAM
Mon–Wed 8:00 AM – 8:00 PM;
Thurs–Fri 8:00 AM – 5:00 PM

Saturday appointments are available in our Londonderry and Bedford offices from 8:00 AM to 3:00 PM
All hours subject to change

HOW TO CONTACT US:

Main Phone: 603-537-1300
Klara Secure Messaging

Website: www.dmcprimarycare.com

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When to Call for Emergency Help

If you feel that your child's condition is life-threatening, you should call the emergency services department in your community at 911 or the emergency services phone number. A rescue team will be directed to evaluate your child and then transport him/her to the hospital.

LIFE-THREATENING CONDITIONS MAY INCLUDE THE FOLLOWING:

1.) Your child has severe difficulty breathing to the point that your child has a gray or blue coloring.

2.) Your child has stopped breathing.

3.) Your child is unconscious (cannot be awakened).

4.) Your child has a serious injury/accident.

5.) Your child has a serious reaction to an insect bite/sting (e.g., difficulty breathing, dizziness, severe hives/rash).

6.) Your child is choking on food and it does not resolve with intervention.

7.) Your child has a seizure or convulsion.

When to Call the Doctor Immediately

YOU SHOULD CALL THE DOCTOR IMMEDIATELY IF:

1.) Your child is having difficulty breathing: if he/she is grunt-breathing, making musical/whistling sounds with each breath or is breathing so that the skin between the ribs sinks in with each breath.

2.) Your child is experiencing lethargy or confusion.

3.) There are signs of dehydration (see DIARRHEA section).

4.) There is uncontrollable vomiting or diarrhea for more than four hours.

5.) There is a rectal temperature greater than 100.4° for infants less than 6 months, greater than 102.2° for 7-36 months or greater than 104° for > 36 months old.

6.) There is bleeding from the mouth (without nosebleed) or the rectum (see DIARRHEA section).

7.) There is blood in the urine of your child.

8.) Your child loses the ability to see or hear.

9.) Your child has an allergic reaction to medication, food or an insect bite/sting.

10.) There is a severe persistent abdominal pain.

11.) A symptom suddenly gets much worse.

12.) Your child has difficulty nodding head up and down (a stiff neck) with a fever.

13.) Your child is coughing up blood.

14.) Your child has a foreign object in the eye.

15.) There is a chance of poisoning (see POISONING section).

16.) There is inconsolable crying/severe pain.

17.) There is pain in testicle or scrotum—needs urgent appointment.

18.) There is trouble swallowing with drooling.

19.) There is a bulging soft spot in infant.

****When you call the doctor, please have:**

1.) Your child's age.

2.) The nature of the symptoms—location of pain, presence of cough, rash (look to be sure), breathing character, diarrhea, vomiting, eating pattern, activity level.

3.) The duration of the symptoms.

4.) The name(s) of any medications you've used and when they were last given.

5.) The child's temperature (for any calls of illness) and the site at which it was taken. Please use a thermometer to obtain the temperature. Do not use your hand or the warmth of your child's forehead as evidence of fever. A rectal temperature is preferred for infants.

6.) Whether anyone else in the family has similar symptoms.

7.) Paper and pen to record instructions.

8.) Any chronic medical problems your child experiences.

9.) A phone number where you can be reached. Please let us know the times you will be unavailable and try to keep the line open for us to call, particularly with emergencies.

10.) The name of your pharmacy, its location and phone number.

- In case of an emergency, if possible, please call the doctor before going to the emergency room.
- Please try to be specific when describing your child's symptoms. For example, say, "Kyle had eight large, watery stools in the last six hours and has drunk four ounces of Gatorade" rather than "Kyle has the runs and isn't drinking a thing."
- If you call the office or answering service and get a busy signal, hang up and redial.
- If there is an emergency, please state this as soon as someone answers.
- Please try to call without a crying child in your arms so that we can hear each other.

DEVELOPMENTAL MILESTONES—A REFERENCE

From the American Academy of Pediatrics' *Pediatric Parent Education* (2021), adapted from Hagan JF Jr, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* [pocket guide]. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017.

Although no two children develop at the same rate, they should be able to do certain things at certain ages. Learning to sit up, walk and talk are some of the major developmental milestones your child will achieve.

Here is information about how babies and young children typically develop. Examples of developmental milestones for ages one month to six years are listed.

NOTE: If you see large differences between your child's age and the milestones listed, talk with your child's doctor.

AT ONE MONTH

SOCIAL	LANGUAGE	MOTOR
■ Looks at parent; follows parent with eyes ■ Has self-comforting behaviors, such as bringing hands to mouth ■ Starts to become fussy when bored; calms when picked up or spoken to ■ Looks briefly at objects	■ Makes brief, short vowel sounds ■ Alerts to unexpected sound; quiets or turns to parent's voice ■ Shows signs of sensitivity to environment (such as excessive crying, tremors or excessive startles) or need for extra support to handle activities of daily living ■ Has different types of cries for hunger and tiredness	■ Moves both arms and both legs together ■ Holds chin up when on tummy ■ Opens fingers slightly when at rest

AT TWO MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Smiles responsively ■ Makes sounds that show happiness or upset	■ Makes short cooing sounds	■ Opens and shuts hands ■ Briefly brings hands together ■ Lifts head and chest when lying on tummy ■ Keeps head steady when held in a sitting position

AT FOUR MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Laughs aloud ■ Looks for parent or another caregiver when upset	■ Turns to voices ■ Makes long cooing sounds	■ Supports self on elbows and wrists when on tummy ■ Rolls over from tummy to back ■ Keeps hands unfisted ■ Plays with fingers near middle of body ■ Grasps objects

AT SIX MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Pats or smiles at own reflection ■ Looks when name is called	■ Babbles with sounds such as “da,” “ga,” “ba” or “ka”	■ Sits briefly without support ■ Rolls over from back to tummy ■ Passes a toy from one hand to another ■ Rakes small objects with four fingers to pick them up ■ Bangs small objects on surface

AT NINE MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Uses basic gestures (such as holding out arms to be picked up or waving bye-bye) ■ Looks for dropped objects ■ Turns consistently when name is called	■ Says “Dada” or “Mama” non-specifically ■ Looks around when hearing things such as “Where’s your bottle?” or “Where’s your blanket?” ■ Copies sounds that parent or another caregiver makes	■ Sits well without support ■ Pulls to stand ■ Moves easily between sitting and lying ■ Crawls on hands and knees ■ Picks up food to eat ■ Picks up small objects with three fingers and thumb ■ Lets go of objects on purpose ■ Bangs objects together

AT 12 MONTHS (ONE YEAR)

SOCIAL	LANGUAGE	MOTOR
■ Looks for hidden objects ■ Imitates new gestures	■ Uses "Dada" or "Mama" specifically ■ Uses one word other than "Mama," "Dada" or a personal name ■ Follows directions with gestures, such as motioning and saying, "Give me (object)"	■ Takes first steps ■ Stands without support ■ Drops an object into a cup ■ Picks up small object with one finger and thumb ■ Picks up food to eat

AT 15 MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Imitates scribbling ■ Drinks from cup with little spilling ■ Points to ask something or get help ■ Looks around after hearing things such as "Where's your ball?" or "Where's your blanket?"	■ Uses three words other than names ■ Speaks in what sounds like an unknown language ■ Follows directions that do not include a gesture	■ Squats to pick up object ■ Crawls up a few steps ■ Runs ■ Makes marks with crayon ■ Drops object into and takes it out of a cup

AT 18 MONTHS

SOCIAL	LANGUAGE	MOTOR
■ Engages with others for play ■ Helps dress and undress self ■ Points to pictures in book or to object of interest to draw parent's attention to it ■ Turns to look at adult if something new happens ■ Begins to scoop with a spoon ■ Uses words to ask for help	■ Identifies at least two body parts ■ Names at least five familiar objects	■ Walks up steps with two feet per step when hand is held ■ Sits in a small chair ■ Carries toy when walking ■ Scribbles spontaneously ■ Throws a small ball a few feet while standing

AT TWO YEARS

SOCIAL	LANGUAGE	MOTOR
■ Plays alongside other children ■ Takes off some clothing ■ Scoops well with a spoon	■ Uses at least 50 words ■ Combines two words into a short phrase or sentence ■ Follows two-part instructions ■ Names at least five body parts ■ Speaks in words that are about 50% understandable by strangers	■ Kicks a ball ■ Jumps off the ground with two feet ■ Runs with coordination ■ Climbs up a ladder at a playground ■ Stacks objects ■ Turns book pages ■ Uses hands to turn objects such as knobs, toys or lids ■ Draws lines

AT TWO AND A HALF YEARS

SOCIAL	LANGUAGE	MOTOR
■ Urinates in a potty or toilet ■ Spears food with fork ■ Washes and dries hands ■ Increasingly engages in imaginary play ■ Tries to get parents to watch by saying, "Look at me!"	■ Uses pronouns correctly	■ Walks up steps while alternating feet ■ Runs well without falling ■ Copies a vertical line ■ Grasps crayon with thumb and fingers instead of fist ■ Catches large balls

AT THREE YEARS

SOCIAL	LANGUAGE	MOTOR
■ Enters bathroom and urinates by himself ■ Puts on coat, jacket or shirt without help ■ Eats without help ■ Engages in imaginative play ■ Plays well with others and shares	■ Uses three-word sentences ■ Speaks in words that are understandable to strangers 75% of the time ■ Tells you a story from a book or TV ■ Compares things by using words such as "bigger" or "shorter" ■ Understands prepositions such as "on" or "under"	■ Pedals a tricycle ■ Climbs on and off couch or chair ■ Jumps forward ■ Draws a single circle ■ Draws a person with head and one other body part ■ Cuts with child scissors

AT FOUR YEARS		
SOCIAL	**LANGUAGE**	**MOTOR**
■ Enters bathroom and has bowel movement by himself ■ Brushes teeth ■ Dresses and undresses without much help ■ Engages in well-developed imaginative play	■ Answers questions such as "What do you do when you are cold?" or "What do you do when you are you sleepy?" ■ Uses four-word sentences ■ Speaks in words that are 100% understandable to strangers ■ Draws recognizable pictures ■ Follows simple rules when playing a board or card game ■ Tells parent a story from a book	■ Hops on one foot ■ Climbs stairs while alternating feet without help ■ Draws a person with at least three body parts ■ Draws a simple cross ■ Unbuttons and buttons medium-sized buttons ■ Grasps pencil with thumb and fingers instead of fist

AT FIVE AND SIX YEARS		
SOCIAL	**LANGUAGE**	**MOTOR**
■ Follows simple directions ■ Dresses with little assistance	■ Has good language skills ■ Can count to ten ■ Names four or more colors	■ Balances on one foot ■ Hops and skips ■ Is able to tie a knot ■ Draws a person with at least six body parts ■ Prints some letters and numbers ■ Can copy a square and a triangle

Well-Child Visits

Remember to take your child to his recommended well-child (health supervision) visits. At each visit, your child's doctor will check his progress and ask you about the ways you see your child growing.

The American Academy of Pediatrics recommends regular well-child visits at the following times:

- Before your baby is born (for first-time parents).
- Before your newborn leaves the hospital.
- Within three to five days after birth and within 48 to 72 hours after leaving the hospital.
- During the first year after birth: Visit by one month of age and also at two, four, six, nine and 12 months of age.
- In early childhood: Visit at 15 months, 18 months, two years and two and a half years of age, as well as yearly visits from three to four years of age.
- In middle childhood: Visit yearly from five to ten years of age.
- In adolescence and early adulthood: Visit yearly from 11 to 21 years of age, until care of your child changes to an adult-oriented physician.

Your family doctor may recommend additional visits. If you have any questions or concerns about your child, talk with your child's doctor. If there is a concern, early treatment is important.

Abdominal Pain

Possible causes of abdominal pain include:

Eating too much—Usually upset stomach/mild pain.

Constipation—Often crampy pain in the lower abdomen, usually relieved by passing a stool. See CONSTIPATION section.

Appendicitis—Appendicitis is characteristically associated with a sharp pain in the right lower abdomen. The pain may start around the belly button or in the upper abdomen but moves to the right side. A child with appendicitis will invariably not want to eat. There may be associated nausea and vomiting, or less frequently, diarrhea. Fever may also be associated, but it is typically not higher than 102° F.

Viral—Usually crampy pain associated with vomiting and diarrhea. Typically lasts around 24 hours: "24-hour stomach flu."

Food poisoning—Pain can be abrupt onset, with vomiting/diarrhea within hours of eating the bad food, and is self-limited, lasting 24 hours.

Strep throat—This can cause abdominal pain in children, often with fever.

Stress/anxiety—A very frequent cause of abdominal pain in children. Over 10% of children can have a nervous stomach. This can often get worse during the school week and better on the weekends.

Home care: Encourage clear fluids (water, flat soft drinks, half-strength Gatorade or Pedialyte). Small, frequent sips are best. Pedialyte popsicles are available. See sections on VOMITING and DIARRHEA or home supportive care for those symptoms. If there is only mild pain and no vomiting/diarrhea, your child can eat a regular diet as tolerated. Avoid ibuprofen, as this could irritate the stomach.

CALL THE DOCTOR IMMEDIATELY IF:

- The abdominal pain is moderate to severe and has persisted for more than two hours, especially if accompanied by fever, chills and not wanting to eat.
- Nausea and vomiting are associated with abdominal pain.
- Blood is in the stool or urine.

CALL THE DOCTOR TODAY IF:

- Mild pain has persisted longer than 24 hours.

Animal Bites

If an animal bites your child, the most important measure is to clean the area with soap and water, then rinse thoroughly. Apply an antibiotic ointment and cover the area, if it is not gaping, with a bandage. Apply pressure to stop bleeding. For bruising, use a cold pack. Acetaminophen or ibuprofen can be used for pain.

If your child is bitten by a wild animal, an unknown domestic animal with unknown vaccination status, a domestic animal acting strangely or the attack was truly unprovoked, you should contact your local animal control officer and our office due to the increased risk of rabies. Of note, bats have been known to spread rabies without any visible mark/bite. Indoor small-animal pets (cats, gerbils, mice, hamsters, etc.) carry no risk of rabies.

Cat bites notoriously can become infected and usually require prophylactic antibiotics to prevent this, and the child should be seen.

Provide instruction to your child on how best to interact with dogs and cats, and always supervise them around animals. Teach them never to approach a dog while feeding.

CALL THE DOCTOR IMMEDIATELY IF:

- Your child's skin is broken (punctured or torn) by an animal or human bite.
- Your child is bitten by any wild animal or a domestic animal that has not received rabies shots or has an unknown vaccination status.
- Your child is exposed to any animal at risk for carrying rabies (e.g., bat, fox, raccoon or skunk). Even being in the same room as a bat without a visible bite is an indication to call for advice.

CALL THE DOCTOR TODAY IF:

- You notice pus or drainage from the wound.
- You have any questions about the status of your child's tetanus vaccinations.
- The area around the bite becomes swollen and red or you notice pus or drainage from the wound.
- You notice swollen glands near the bite.

Asthma

Asthma is a condition characterized by shortness of breath, tightness in the chest, exercise intolerance, wheezing (a whistling or musical noise usually noted more when breathing out) and/or a tight, dry cough. Children with asthma are often worse at night or when they have viral infections (colds) or when exposed to allergens. Exercise can also induce symptoms.

If your child has asthma, our physicians will prescribe various medications. There are two types of medication. The first type is rescue medications that your child should use when they have symptoms or prior to exercising to prevent symptoms. These are typically albuterol-containing inhalers (brand names Proair, Ventolin, Proventil). The other type is controller medications. These can include a steroid to reduce inflammation in the lungs, sometimes accompanied by a long-acting bronchodilator. There are also oral medications that can be used to control asthma. Sometimes a combination medication, such as Symbicort, can be used for both controlling and rescue treatment. Your doctor will always give you instructions on how to use each inhaler. Your child must rinse their mouth out after using any inhaler with a steroid to prevent thrush. You should always have medication for asthma on hand. Please call during regular office hours for a refill of medication.

Your doctor may discuss using a peak flow meter and having a written asthma action plan.

You may need a doctor's note from our office to allow your child to use medications at school.

CALL FOR EMERGENCY HELP IF:

- Your child has severe difficulty breathing and/or is turning blue.
- Your child is straining for each breath, with nostrils flaring and chest heaving.

CALL THE DOCTOR IMMEDIATELY IF:

- Your child has previously been diagnosed with asthma but is not responding to the usual measures.
- Your child is wheezing hard and visibly tiring.

CALL THE DOCTOR TODAY IF:

- Your child is wheezing or struggling to breathe for the first time.
- Your child's symptoms are accompanied by fever or chest pain.
- Your child continues to wheeze and have difficulty breathing even while using prescription medications.
- Your child has asthma symptoms more than once or twice a week or wakes up at night with asthma symptoms more than twice a month.

Bites/Stings

Insect bites can cause considerable swelling in infants and young children.

To prevent bites, we recommend using long pants and long sleeves for infants.

WHAT YOU CAN DO:

To reduce the likelihood of your child getting insect bites and stings, follow these precautions:

Repel insects. Protect infants from mosquito bites by using a carrier draped with a mosquito netting with an elastic edge for a tight fit. If your child is over two months old, use insect repellents containing the chemical DEET, but very sparingly. Do not apply to young children's hands or around eyes and mouth. The chemical can be toxic if swallowed. Don't use insect repellent on skin that is cut, scratched, wounded or sunburned. When choosing insect repellent containing DEET, look on the label for a product containing less than 30 percent. If using for only a short period of time (less than two hours), 10% should be adequate.

Whereas DEET is put on the skin, you can use permethrin products on clothing. Products that contain permethrin work well to repel insects and ticks. Examples of these products are Duranon or Permanone. Put it on shirt cuffs, pant cuffs, shoes and hats. You can also use it on other outdoor items (mosquito screens, sleeping bags). Do not put permethrin on the skin (reason: Sweat changes it so it does not work).

Perform an insect search. You should check your child's skin for insects every time your child comes in from playing in the woods or in an area known to be infested with ticks or other insects. Do the same with your pets.

Cover up your child. To protect your child from insect stings, have him wear lightweight long pants and long-sleeved shirts. Although some insects can sting right through some fabrics, you'll reduce the chances of a sting.

Bring your child indoors at dusk. Dusk is the time of day when mosquitoes are most active.

WHAT YOU CAN DO:

Most insect bites are harmless and resolve on their own. Follow the suggestions below for home treatment if an insect bites or stings a child.

Bee and Wasp Stings: First, check if the insect's stinger is still in your child's skin. If so, it will look like a little black dot in the middle of the bump. Remove it by scraping it off with the edge of scissors, a plastic credit card, a fingernail or by plucking it out with tweezers. Once you've removed the stinger, apply an ice pack followed by a paste of baking soda and water to soothe the skin and relieve the itching. Acetaminophen or ibuprofen can be given for pain.

Mosquito, Mite and Flea Bites: These are less painful but itchy bites. The itch is often difficult to soothe. A paste of baking soda and water may help, as well as an over-the-counter (OTC) steroid cream. Also, you can put firm, sharp, direct, steady pressure on the bite. Do this for ten seconds to reduce the itch. A fingernail, pen cap or other object can be used. If the itching is severe, ask your doctor if you should give your child an OTC antihistamine to reduce the irritation.

If the bite has a scab and looks infected, use an antibiotic ointment. An example is Polysporin. No prescription is needed. Use three times per day. (Note: Usually impetigo is caused by scratching bites with dirty fingers.) Cover the scab with a Band-Aid to prevent scratching and spread. Wash the sore and use the antibiotic ointment three times per day. Do this until healed.

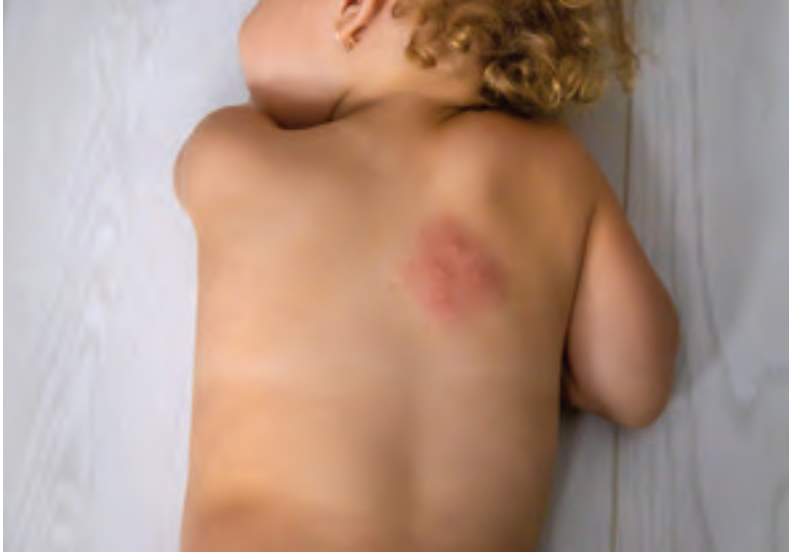
Most insect bites are itchy for several days. Any pinkness or redness usually lasts three days. The swelling may last seven days.

Spider Bites: If you have any reason to believe that a black widow or brown recluse spider bit your child, call your doctor immediately. Otherwise, clean the area around the bite and apply an ice pack to reduce swelling and soreness.

Tick Bites: First, remove the tick using tweezers placed as close to the tick's head as possible. Pull with slow, steady pressure. Do not twist or jerk the tick, which may cause the body to break off, leaving the head and mouthparts embedded in the skin. If it doesn't come out easily, do not crush or tug at it. If the head remains in the skin, call your doctor. Other options: You can use a loop of thread around the jaws. You can also use a needle pushed between the jaws for traction. Jaws are the part of the head attached to the skin. Not helpful: Covering the tick with petroleum jelly or nail polish doesn't work. Neither does rubbing alcohol or a soapy cotton ball. Touching the tick with a hot or cold object also doesn't work. Once you've removed the tick, drown it in some water mixed with detergent. Wash the wound and your hands thoroughly with soap and water.

Lyme disease is caused by a bacterium that is transmitted by a bite from a deer tick. This tick is very small (about the size of a sesame seed or head of a pin). The risk of Lyme disease after a deer tick bite is low. Even in a high-risk area like New Hampshire, the risk is about two percent. Most infections (80%) start with a bull's eye rash. The medical name is erythema migrans (EM). The rash starts at the site of the tick bite. EM is usually solid red. Central clearing is present in 30%. EM starts on average at seven days. It grows larger quickly to more than two inches (five cm) wide. It lasts two or three weeks.

Giving an antibiotic after a deer tick bite to prevent Lyme disease depends on the risk. The risk is low with brief attachment. An antibiotic is not needed. The risk is high if the deer tick was attached for longer than 36 hours. It's also high if the tick is swollen, not flat. An antibiotic may be needed. Your doctor will help you decide.



CALL FOR EMERGENCY HELP IF:

- Your child has difficulty breathing or throat tightness or seizures.
- Your child experiences immediate swelling of the entire body or hives (raised layered patches on the skin) located away from insect sting/bite.
- Your child has a known severe bee sting allergy and is stung by a bee.
- Your child develops signs of allergic shock (rapid pulse; clammy, pale skin; sweating; and faintness).

CALL THE DOCTOR IMMEDIATELY IF:

- Your child vomits, becomes dizzy or has a fever after being stung.

CALL THE DOCTOR TODAY IF:

- Your child has a large skin reaction around the location of the sting (larger than one inch).
- A red rash begins at the site of an insect bite (especially a tick bite) and grows larger for several days.
- You notice symptoms of Lyme disease (circular red rash, headache, fever, fatigue, muscle pain, neck pain) within a few days to weeks after a tick bite.
- You remove a tick and believe it to have been there longer than 36 hours or cannot be sure the length of time attached.

Burn (See also SUNBURN)

Burns are classified according to their severity and the depth of skin involved:

First-degree burns involve only the upper layers of the skin and are characterized by pain and redness without blisters.

Second-degree burns involve the middle layers of skin and are characterized by blister formation along with redness and pain. Heals from the bottom up. Takes two to three weeks to heal.

Third-degree burns involve the deepest layers of skin. There is no associated pain because of nerve damage. Blisters may or may not be present. Heals from the edges. Skin grafts are sometimes needed depending on the size of the burn.

WHAT TO DO:

- Try to determine the severity of the burn.
- Wash the burn gently with warm water. Do not use soap unless the burn is dirty.
- Place a cool, wet washcloth on the burn and give acetaminophen or ibuprofen for pain.
- Don't open any blisters—blisters are a natural protective bandage.
- If blisters do become broken, use an OTC antibacterial ointment and cover with an adhesive bandage. Clean the area and change the dressing and re-apply ointment daily.
- If the burn appears to be a first-degree or second-degree burn, cover the burn with a sterile cotton bandage.

CALL FOR EMERGENCY HELP IF:

- A significant portion of the body has been burned (more than the area of one arm or leg).
- An extensive burn involves the hands, feet, face or genitals.
- Your child has difficulty breathing.

CALL THE DOCTOR IMMEDIATELY IF:

- A significant portion of the body has been burned (more than the area of a hand).
- There is no pain associated with the burn.

CALL THE DOCTOR TODAY IF:

- Your child has not had a tetanus booster within five (5) years.
- The burn is covered by blisters that break spontaneously.
- Thick, yellow drainage develops at the burn site.
- Red streaks radiate from the burn site.
- Your child develops a fever.

Colds (Upper Respiratory Infections) (See also COUGH)

Colds are caused by viruses. There are thousands of viruses that cause cold symptoms. The symptoms include low-grade fever, runny or stuffy nose, swollen lymph glands in the neck, coughing and watery eyes. The nasal discharge may be clear to yellow to green at times during the cold. If the colored discharge persists for longer than ten days, see SINUSITIS. Cold symptoms can last up to 14 days. Hand washing is the most effective way to prevent the spread of cold viruses. To alleviate symptoms, we do NOT recommend OTC cold medications. They have not been shown to benefit children and are contraindicated in children under six years old.

Antibiotics will NOT help to cure a cold.

For runny nose: The nasal mucus and discharge is washing germs out of the nose and sinuses.

- Blowing the nose is all that's needed.
- Teach your child how to blow the nose at age two or three.
- For younger children, gently suction the nose with a suction bulb.

Nasal saline can be helpful to loosen/thin the mucous:

- Use saline (salt water) nose drops or spray to loosen up the dried mucus. If you don't have saline, you can use a few drops of bottled water or clean tap water. (If under one year old, use bottled water or boiled tap water.)
- STEP 1: Put three drops in each nostril. (If under one year old, do one side at a time.)
- STEP 2: Blow (or suction) each nostril out while closing off the other nostril.
- STEP 3: Repeat nose drops and blowing (or suctioning) until the discharge is clear.
- How often: Do nasal saline when your child can't breathe through the nose.
- Saline nose drops or spray can be bought in any drugstore. No prescription is needed.
- Saline nose drops can also be made at home. Use 1/2 teaspoon (2 ml) of table salt. Stir the salt into one cup (eight ounces or 240 ml) of water. You must use bottled or boiled water for this purpose.
- Reason for nose drops: Suction or blowing alone can't remove dried or sticky mucus. Also, babies can't nurse or drink from a bottle unless the nose is open.
- Other option: Use a warm shower to loosen mucus. Breathe in moist air, then blow each nostril.
- For young children, you can also use a wet cotton swab to remove sticky mucus.
- Humidifier and encouraging oral hydration can also help.

For fever: You may use acetaminophen or ibuprofen (see FEVER section for dose) in the appropriate dose along with cold medications.

Do not give your child aspirin.

For cough: For children over one year old, give honey 1/2 teaspoon (2 ml). Cough drops may be used only after age six.

For sore throat: Popsicles, ice cream, warm chicken broth.

CALL FOR EMERGENCY HELP IF:

- Your child has severe difficulty breathing and/or is turning a gray or blue color.

CALL THE DOCTOR IMMEDIATELY IF:

- There is a rectal temperature greater than 100.4° for infants less than 6 months, greater than 102.2° for 7-36 months or greater than 104° for > 36 months old.
- Fever without other symptoms lasts more than 24 hours and age is less than two years.
- Fever lasts more than three days (72 hours).
- If your child's fever brings on a seizure or convulsion.
- If other symptoms appear, such as ear pain, persistent sore throat, persistent vomiting, diarrhea or if your child appears dehydrated.
- If your child develops a rash and a fever.

CALL THE DOCTOR TODAY IF:

- Your child's cold symptoms get worse instead of improving after three to five days.
- Your child has a sore throat that does NOT improve after 24 to 48 hours.

Colic

Colic is defined as periods of unexplained crying in a young infant, sometimes associated with drawing up the legs. It usually begins before or around two weeks of age and stops abruptly at around three months of age. Babies are usually consolable if held and comforted and are happy in between these bouts of crying.

Colic is due to your baby's sensitive, alert temperament. It's also called normal fussy crying. It usually occurs at times when your baby is sleepy. Please note, it has nothing to do with your parenting. It is NOT caused by gas, spitting up or stomach pain.

All crying babies pass lots of gas and their stomachs also make lots of gassy noises. The gas comes from swallowed air and is normal. Sometimes colic can be associated with feeding too much. Some babies cry more because of a bloated stomach from overfeeding. Too much milk can cause discomfort that lasts a short time.

TIPS:

If the baby is crying, feed only if it has been more than two hours since last feeding if formula-fed and only if more than one and a half hours since last feeding if breastfed. If breastfeeding, avoid caffeine intake or limit to two servings per day.

Hold and comfort your baby; rock the baby while standing or in a cradle or rocking chair.

Tiny vibrations should help, like a vibrating bouncy chair.

Go for a walk with the baby in the stroller, or take a ride in the car. The movement helps.

You can try a pacifier, infant massage or a warm bath.

Try swaddling babies under two months old. Stop swaddling once the baby is two months.

Try white noise in the background, not too loud (white noise sleep sounds CD, vacuum cleaner, fan).

If your baby has been awake for at least two hours and no other measures seem to help, they may be overtired. Try putting them down for a nap, swaddled (if under two months old), with white noise.

There are times when nothing seems to console a child with colic. It can be very frustrating. Know that it is a self-limited condition and usually is better by age three months. If you get frustrated, put the baby down in a safe place and take a break. Call for help. Remember, never shake a baby, as it can cause bleeding in the brain and permanent damage. If you do leave the baby with someone else for a break, make sure it is a trusted person who does not easily get frustrated or have a bad temper.

For further reading, try "Happiest Baby on the Block"—see information in Recommended Reading section.

CALL YOUR DOCTOR IF:

- Your baby starts to look or act abnormal.
- Your baby cries nonstop for more than two hours.
- Your child can't be consoled using this advice.
- You think your child needs to be seen.
- Your child becomes worse.

Constipation

Constipation means infrequent, firm bowel movements. Children may experience constipation because of decreased fluid intake, decreased fiber intake, after an episode of diarrhea or, for infants, with the introduction of solid foods.

BABIES UNDER ONE YEAR:

The bowel movements of breastfed infants are very soft to watery, and in the first weeks of life, usually occur after every feeding. As the infant matures, the bowel movements become less frequent. Stools every four to seven days that are soft, large and pain-free can be normal, and occur in 20% of breastfed babies over one month old. If under one month, this could be a sign of not getting enough to eat.

Formula-fed infants have more formed bowel movements.

Grunting or straining while pushing out a stool is normal in young babies. It's hard to pass stool lying on the back with no help from gravity. Becoming red in the face during straining is also normal. However, if the straining occurs for longer than ten minutes without stool passage and they appear to be in pain or cry when passing a stool, your child may be constipated.

For babies over one month old, you can add fruit juice (e.g., apple or pear juice). After three months, you can use prune (plum) juice.

Amount: one ounce (30 ml) per month of age each day, up to a maximum amount of four ounces (120 ml) per day (i.e., after four months of age, the dose is set at four ounces per day).

If your baby is over four months old, you can also add baby foods with high fiber. Do this twice a day. Examples are peas, beans, apricots, prunes, peaches, pears or plums.

If on finger foods, add cereals and small pieces of fresh fruit.

Help your baby by holding the knees against the chest. This is like squatting for your baby. This is the natural position for pushing out a stool. It's hard to have a stool lying down. Relax the legs, then press up again. Move them like riding a bike. You can also gently pump on the lower abdomen. If no stool releases within five minutes, stop. Try it again next time.

You can try warm water on the anus, either via a warm, wet washcloth or cotton ball. Never put anything inside the anus.

AGE OVER ONE YEAR:

Once children are on normal table foods, their stool pattern is like adults. The normal range is three stools per day to one every two days. Symptoms of constipation include straining for longer than ten minutes, pain with passage of stool or hard, small stools like pellets. Kids who only go every four or five days almost always have pain with passage. Kids who go every three days are in danger of becoming worse and developing symptoms.

Causes of constipation in this age group include too much cheese or milk in the diet, a low-fiber diet and stool withholding (avoiding having a bowel movement due to anticipated pain, not wanting to use the bathroom at school or power struggles associated with toilet training). Any child with pain during stool passage or infrequent stools needs intervention of some kind, as outlined below.

Position: Try a squatted position with knees higher than hips. This can be facilitated with a foot stool.

Increase fruit juice (apple, pear, cherry, grape, prune). Citrus juice is not helpful. Add fruits and vegetables high in fiber content. Examples are peas, beans, broccoli, bananas, apricots, peaches, pears, figs, prunes or dates. Increase whole grain foods. Examples are bran flakes or muffins, graham crackers and oatmeal. Brown rice and whole wheat bread are also helpful. Limit milk products (milk,

ice cream, cheese, yogurt) to three servings per day. One dairy product that may help is probiotic yogurt or liquid drinks (e.g., Activia yogurt, Good Belly drinks). Give one serving per day on an empty stomach (no food for the previous two hours).

If a change in diet doesn't help, you can add a stool softener. Miralax is a good one. Give it each day with dinner. Try to phase it out after a week.

Miralax dose for ages one to five: One teaspoon powder mixed in two ounces (60 ml) of water or fruit juice.

Miralax dose for ages over five years: Two teaspoons in four ounces (120 ml) of water or fruit juice.

If toilet trained, encourage your child to sit on the toilet for at least five minutes 20 minutes after meals. After breakfast is the best time, with the strongest intestinal contractions assisting. If age appropriate, stay with your child as a coach. Do not allow your child to be distracted by other things during the sitting. Once your child passes a bowel movement, he or she does not need to sit any more that day.

If toilet training and stool holding happens, put your child back in diapers or pull-ups for a while. Praise him or her for stooling in the diaper and give rewards.

Call if your child goes more than a week without a stool or if your child is getting worse.

Cough (See also COLDS, FEVER, CROUP)

Coughing may be a symptom of several illnesses. Most common are benign cold viruses. Influenza, RSV, croup and COVID-19 are other causes of viral cough. More serious causes are whooping cough, pneumonia or foreign body.

Coughs can be dry or moist, with sputum production. The color of the sputum is not an indicator of viral vs. bacterial. Viral illnesses can produce yellow or green sputum.

Vomiting can occur with coughing fits. If this happens, reduce the amount per feeding, as this happens more with a full stomach.

It is important to note that viral coughs can normally last two to three weeks.

Signs of respiratory distress that require medical attention include:

- Struggling for each breath or shortness of breath.
- Tight breathing to the point that your child can barely speak or cry.
- Ribs are pulling in with each breath (called retractions).
- Breathing has become noisy (such as wheezes or stridor—whistling noises with expiration or inspiration).

We do not recommend treating coughs with OTC medications, as they have generally been proven to be ineffective. They are also contraindicated for those children under age six.

Try these home remedies instead:

- AGE three months to one year: Give warm, clear fluids to treat the cough. Examples are warm apple juice and lemonade. Amount: Use a dose of one to three teaspoons (5–15 ml). Give four times per day when coughing. Caution: Do not use honey until one year old.
- AGE one year and older: Use ½ teaspoon (2 ml) HONEY as needed. It's the best homemade cough medicine. It can thin the secretions and loosen the cough. If you don't have any honey, you can use corn syrup.
- Any age: Breathe warm mist (turn on hot shower water and sit with your child in a closed bathroom). Push fluids. Humidifier.

If you decide to buy a cough medicine for a child aged six or up, choose one with dextromethorphan (DM). It's present in most non-prescription cough syrups. Give only for severe coughs that interfere with sleep or school. Give every six to eight hours as needed.

CALL THE DOCTOR IMMEDIATELY IF:

- There is a rectal temperature greater than 100.4° for infants less than 6 months, greater than 102.2° for 7-36 months or greater than 104° for > 36 months old.
- Your child has signs of respiratory distress (see above).
- Your child has a cough and is less than three months old.
- Your child's cough is violent or persistent (does not stop).
- You suspect that your child may have swallowed or inhaled a small object.

CALL THE DOCTOR TODAY IF:

- Your child develops a fever and the cough becomes worse after a week.
- Your child's cough persists for more than three weeks.

Croup (See also COLDS and/or COUGH)

Croup is a viral illness that is typically much more severe at night. The characteristic "barking" cough results from a narrowed airway. There can also be stridor, an obstructive sound made on inspiration. Older children may have laryngitis as a result of the same virus that causes croup in younger children. Croup can last five to six days, and the cough can linger for two weeks. It can be accompanied by a fever (see FEVER section). Symptoms typically can get worse at night. To treat the cough, see the section on COUGH for remedies and general measures, including humidifiers, pushing fluids, etc. Some cases of croup can be treated with supportive care, but the more severe cases need to be treated with steroids and even hospitalization.

If your child awakens with whooping noise (stridor) with inspiration (breathing in), do the following:

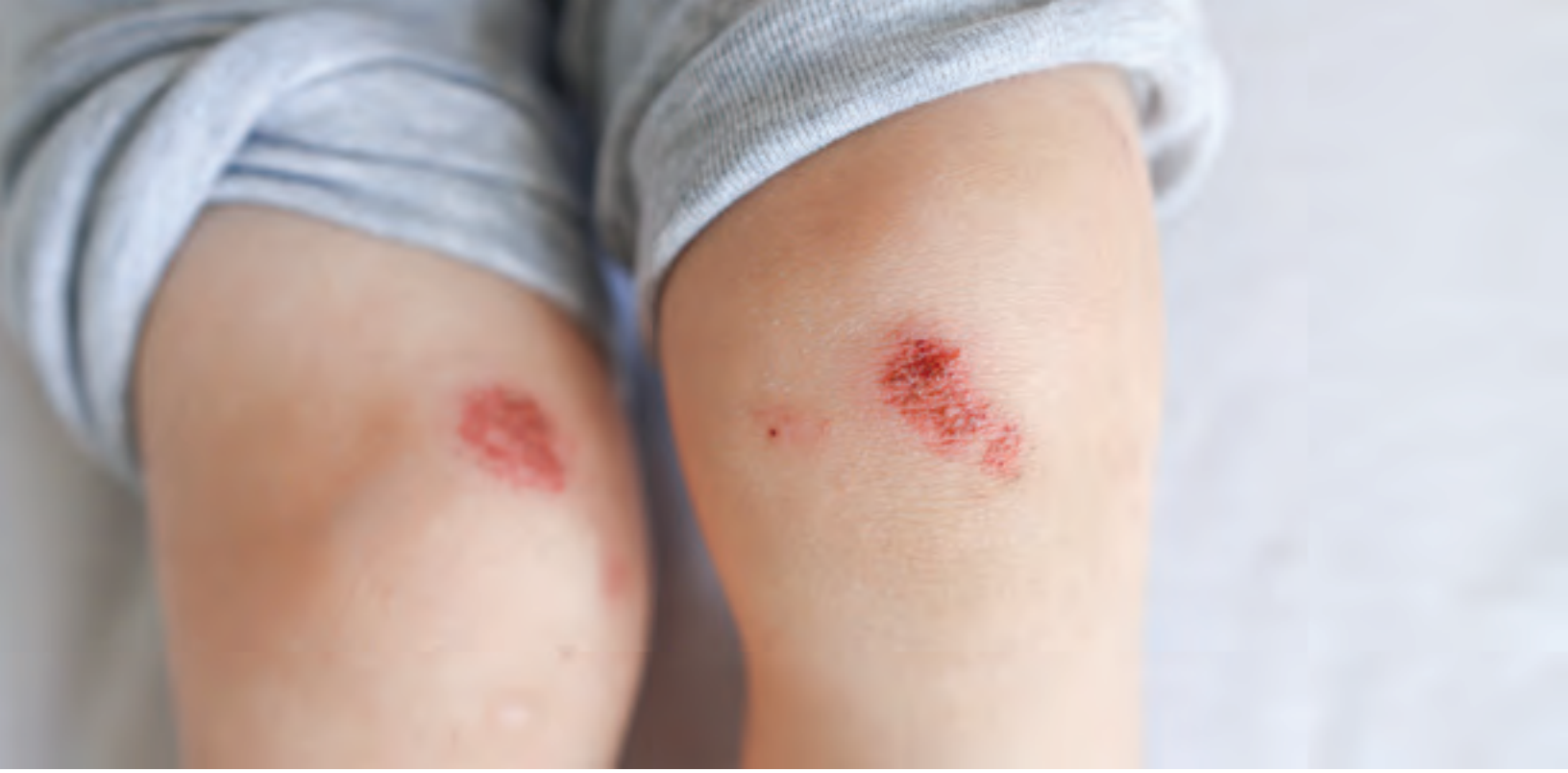
1. Run the shower with the bathroom door closed and take the child into the bathroom with you for 15–20 minutes.
2. If the above does not alleviate the symptoms, take the child outdoors for 15–20 minutes, or stand in front of an open refrigerator. Cool air will often alleviate the symptoms.
3. If your child has stridor, try to calm your child. Crying will make stridor worse.
4. You may need to repeat steps 1–3 during the night, and it is best to sleep in the same room with your child.
5. If your child's symptoms have not improved after the above measures, your child needs immediate medical attention.

CALL FOR EMERGENCY HELP IF:

- Your child is struggling to breathe.
- Your child is using the muscles of his rib cage to breathe or his neck muscles appear to be sucked in with each breath.
- Your child's lips become a bluish or grayish color.
- Your child is experiencing stridor at rest.

CALL THE DOCTOR IMMEDIATELY IF:

- Your infant under 6 months old has croup or a persistent cough
- There is a rectal temperature greater than 100.4° for infants less than 6 months, greater than 102.2° for 7-36 months or greater than 104° for > 36 months old.



Cuts/Scrapes

Cuts vs. Scrapes: The skin is about 1/8 inch (3 mm) thick. A cut (laceration) goes through it. A scratch or scrape (wide scratch) doesn't go through the skin.

Steps to follow with minor cuts and scrapes:

1. Clean the area thoroughly with soap and water for five minutes, then rinse under running water (don't soak).
2. Apply direct pressure with a gauze to stop bleeding.
3. Apply Bacitracin or similar antibiotic cream.
4. Cover the area with a bandage.
5. Change the bandage daily or if it gets wet or dirty.

Alternative to bandage: Liquid skin bandage seals wounds with a plastic coating. It lasts up to one week. Use for any small break in the skin. Examples are paper cuts, hangnails and cracks on the fingers or toes. Liquid skin bandage has several benefits compared to other bandages (such as Band-Aid). Liquid bandage only needs to be put on once. It seals the wound and may promote faster healing and lower infection rates. Also, it's waterproof, so they can shower (but don't soak it). Wash and dry the wound first as above. Then, put on the liquid. It comes with a small brush. It dries in less than a minute. You can get this product at a drugstore near you. There are many brands of liquid bandage. No prescription is needed. The store brand of this product costs less than five dollars.

CALL THE DOCTOR IMMEDIATELY IF:

- The wound is gaping, large (½ inch on body, ¼ inch on face) and/or deep (more than ⅛ inch from side to side).
- Bleeding continues even after pressure has been applied for 15–20 minutes.
- A wound is one to three days old and is infected (redness, warmth, pain, swelling and thick, yellow drainage).
- Red streaks develop around the wound.
- Your child has a fever or swollen glands near the wound (neck, under arms, groin).

CALL THE DOCTOR TODAY IF:

- Your child has not had a tetanus shot within five years.
- Dirt, glass or debris is stuck to a large wound—this may need to be removed.

Diaper Rash

Some infants in diapers seem to have almost constant rashes, while others seem never to have skin breakdown. Causes of diaper rash include the drying effect of some soaps, infrequent diaper changes causing irritation by urine/feces, diarrheal illnesses and yeast infections.

To treat diaper rash, wash the diaper area with warm water and mild soap (such as Dove), then apply cream or ointment (e.g., Desitin, Balmex, A&D, Buttpaste or Vaseline/Aquaphor). Don't rely on baby wipes alone to clean, as these can leave a film of bacteria. Change the diapers as frequently as possible to prevent your child remaining in a wet or soiled diaper. If possible, allow your child to remain without a diaper for a time—exposure to air is good.

If the rash becomes bright red with small dots separated from the main rash, your child may have a yeast infection. This is primarily common if your child is on antibiotics. For a yeast infection, we recommend the above measures with the addition of Lotrimin AF cream twice a day. Continue to use the medication for one to two days after the rash has cleared.

If the rash does not respond to the above measures after several days, call the office during regular office hours.

CALL THE DOCTOR IMMEDIATELY IF:

- Your child has rashes elsewhere on his/her body or if a fever accompanies their rash.
- The rash is getting worse by the hour.

Diarrhea/Dehydration

Diarrhea means frequent, watery bowel movements. It is most often the result of a viral illness, but it can be bacterial or from food poisoning. Severe diarrhea usually lasts only a few days, but lingering mild diarrhea or loose stools can last up to two weeks.

Degrees of diarrhea include MILD (two to five watery stools per day), MODERATE (six to nine watery stools per day) and SEVERE (ten or more watery stools per day).

Diarrhea is usually self-limited. The most important thing to do when your child has diarrhea is to prevent dehydration. Signs of dehydration can include dry mouth, crying without tears, eyes appearing less glistening, lethargy/fatigue, not being able to stand, sunken soft spot in infants and decreased urination. If your child is less than one year of age, there should be at least three wet diapers per day. If your child is over one year of age, your child should urinate at least twice in 24 hours.

MILD DIARRHEA

Breastfed babies: Offer more breast milk if breastfeeding. Supplement with formula if necessary. Offer more formula if formula-fed. If on solids, offer more starchy foods (cereals, crackers, rice). Avoid juices or "P"-type foods (pears, peaches, prunes), as these can loosen the stools.

Age over one year: Keep on a normal diet. Drink more fluids. Milk is a good choice for diarrhea. Do not use fruit juices. Reason: They can make diarrhea worse. Eat more starchy foods. Give dried cereals, oatmeal, bread, crackers, pasta, mashed potatoes or rice. Pretzels or salty crackers can help meet salt needs. You can give yogurt—give two to six ounces (60 to 180 ml) of yogurt. Do this twice daily. Note: Look for "probiotic" yogurts.

MODERATE/SEVERE DIARRHEA

Babies under one year: Offer more breast milk or formula. If breastfeeding, you may supplement with formula. Consider using an oral rehydration solution (ORS), such as Pedialyte. Give two to four ounces (60 to 120 ml) of ORS after every large, watery stool. This is in addition to breast milk or formula. And if on solids, offer more starchy foods (cereals, crackers, rice). Avoid juices. Monitor for dehydration.

Age over one year: Offer as much fluid as your child will drink. If also eating solid foods, water is fine. So is Pedialyte, half-strength Gatorade or half-strength apple juice. If not eating solid foods, use milk as the fluid. Do not use other fruit juices or soft drinks, as they might make diarrhea worse. Give dried cereals, oatmeal, bread, crackers, pasta, mashed potatoes or rice. Pretzels or salty crackers can help meet salt needs. You can give yogurt—give two to six ounces (60 to 180 ml) of yogurt. Do this twice daily. Note: Look for "probiotic" yogurts. Monitor for dehydration.

Pay special attention to the diaper area, which may become irritated. Change soiled diapers promptly, then wash and dry your child's bottom with a warm, wet washcloth. Spread petroleum jelly, Desitin, Balmex or A&D ointment on the diaper area to protect from diaper rash. See diaper rash section.

CAUTIONS:

Do NOT keep your child on only liquids for more than 24 hours. Add crackers that have salt (such as saltines), dry cereal (Cheerios) or toast to your child's diet as soon as tolerated. Other comfort foods for diarrhea include rice, bananas, yogurt and plain pasta.

Do NOT give over-the-counter anti-diarrheal products unless instructed by the doctor.

CALL THE DOCTOR IMMEDIATELY IF:

- You suspect that your child is dehydrated.
- Your child has diarrhea with abdominal pain that lasts more than two to three hours.
- There is blood in the stool.
- Your child has severe abdominal pain.
- Your child has diarrhea AND a high fever.
- Your child has diarrhea and a rash or jaundice (yellow eyes).

CALL THE DOCTOR TODAY IF:

- You suspect food poisoning (she has eaten seafood, undercooked hamburger, etc.).
- Your child is less than six months old and has symptoms of diarrhea.
- Your older child's diarrhea lasts longer than two to three days and has other symptoms of illness, such as fever, rash or vomiting.
- Your child has diarrhea lasting longer than two weeks.
- There is any worsening or you feel your child needs to be seen.

Ear Infections/Earache

An earache may occur from two types of infection to the ear. The most common type of ear infection is the middle ear infection, or acute otitis media. The other type is called otitis externa, or swimmer's ear. This is an infection of the ear canal (see SWIMMER'S EAR).

Middle ear infections usually occur after the onset of a cold (upper respiratory infection). There may or may not be a fever. A child may tug at the affected ear or awaken more frequently than usual from sleep or be fussier. Occasionally, there may be fluid draining from the ear. You may notice that your child is not hearing normally.

Ear infections are not an emergency. Not all ear infections need to be treated with antibiotics, and in some cases, observation may be offered or recommended. We usually do not call in antibiotics for ear infections without seeing your child.

Ear pain can also result from a blocked eustachian tube. Clearing the mucous from the nose can help (see section on COLDS for instructions for clearing the nose with saline drops and suctioning/blowing). OTC medications for congestion are not generally recommended. If your child has allergies, allergy medication may be recommended.

If antibiotics are prescribed, they usually take 24–48 hours to have an effect on the infection and reduce pain. Meanwhile, you may give acetaminophen/ibuprofen to reduce pain (see FEVER section for correct dose). Elevating the head of their bed may allow your child to sleep more comfortably. Many children find that a warm—**not hot!**—water bottle held against the ear helps to relieve the pain.

Ear infections are not contagious. Your child may go to school or daycare.

There is no association between middle ear infections and swimming or getting water in the ear. If there is no drainage from the ear, your child may swim. There is no need to cover the ear when going outside.

If your child needs to fly with an ear infection, please discuss this with your doctor. We recommend a pacifier or feeding the child during takeoff and landing. Older children may chew gum.

You can decrease the number of ear infections by not allowing your child to fall asleep drinking a bottle AND not allowing smoke (cigarette or pipe) in your house, car or daycare environment. Breastfeeding your infant helps decrease the risk of ear infections. Limit pacifier use to daytime (only if your child is over one year old).

We may recommend a follow-up appointment to ensure that the infection is completely cleared (so that the child can hear normally).

CALL THE DOCTOR IMMEDIATELY IF:

- Your child develops a stiff neck, severe headache or seizure.
- Your child has severe pain that is not relieved by acetaminophen or ibuprofen.
- Your child cannot walk normally or is extremely dizzy.
- Your child is lethargic (very weak) and appears very sick to you.
- The earache occurred following an injury to the ear and has blood draining from the ear.

CALL THE DOCTOR TODAY IF:

- You suspect that your child has an ear infection.
- There is liquid draining from your child's ear.
- Your child has difficulty hearing and/or complains of buzzing or ringing.
- Your child's ear pain and/or fever is not gone after taking antibiotics for 72 hours.
- Your child has an ear infection and refuses the antibiotic or vomits a medication repeatedly.

Eye Infection (Conjunctivitis/Pink Eye)

Pink eyes can result from viruses, allergies or bacteria, as well as irritants and foreign bodies. Viral conjunctivitis commonly occurs with a cold. It is usually bilateral and may include watery discharge. Allergic conjunctivitis is also usually bilateral, with watery discharge, and it is associated with allergies. Bacterial conjunctivitis is more likely to be unilateral and has green or yellow discharge with crusting.

Home care includes gently cleaning the eyes with warm water and a clean cotton ball. In addition, you can use artificial tears (OTC) and this usually soothes a pink eye. Use one drop three times a day as needed.

Conjunctivitis from allergies is usually treated with oral medication and/or eye drops for allergies.

Conjunctivitis from a viral cold usually is self-limited and goes away after seven days. Sometimes, the viral conjunctivitis can turn into a bacterial infection.

If your child is diagnosed with bacterial conjunctivitis, antibiotic drops will be prescribed. Schools and daycares usually require the use of the antibiotic drops for 24 hours prior to return to school. Before using antibiotics in the eyes, clean any discharge from the eye with a cotton ball soaked in warm water. Wipe the inside corner of the eye with a fresh cotton ball every time you see discharge.

To instill drops: For a cooperative child, gently pull down on the lower lid. Put one drop inside the lower lid. Then ask your child to close the eye for two minutes. Reason: so the medicine will get into the tissues. For a child who won't open his eye, have him lie down. Put one drop over the inner corner of the eye. If your child opens the eye or blinks, the eye drop will flow in. If he doesn't open the eye, the drop will slowly seep into the eye. Two people can instill antibiotic drops/ointment more easily than one. If you must do it alone, sit on the floor and hold your child's head, face up, between your knees.

You can reduce the chance of spreading infections, viral and bacterial, by washing both your hands and your child's hands frequently. Also, change your child's washcloth and towel daily and do not allow others to share his towel or washcloth. Frequently wash your child's pillowcase when symptoms develop. Finally, do not touch the dropper or tube to your child's eye when instilling medications.

Conjunctivitis is not an emergency. Pink eye with watery discharge is harmless. There is a slight risk it could be passed to others. Children with pink eyes from a cold do not need to miss any school. Pink eye is not a public health risk. Keeping these children home is overreacting. If asked, tell the school your child is on eye drops (artificial tears).

CALL THE DOCTOR IMMEDIATELY IF:

- Your child's eye is swollen shut.
- The eyelid is dark red or violet color and appears swollen.
- Your child complains of blurred or double vision.

CALL THE DOCTOR TODAY IF:

- You suspect that your child has signs of conjunctivitis.
- Your child's eye becomes itchier or reddened after instilling the medication (stop the medication and call).
- Your child has not improved after 72 hours of treatment.

Febrile Seizures

Approximately two to five percent of children experience febrile seizures. Febrile seizures are convulsions associated with fever. The child usually loses consciousness, eyes roll back and he or she becomes stiff or twitches for several minutes. Most febrile seizures last less than one minute but can last up to 15 minutes, although this is rare. The movement then stops and then the child regains consciousness, but he or she may be sleepy and groggy for 30–90 minutes afterward. Febrile seizures usually occur between the ages of six months and five years.

Febrile seizures are not epilepsy. Epilepsy is characterized by repeated seizures without fever.

Although febrile seizures are scary, they are generally harmless and do not cause brain damage, cognitive issues, learning disabilities or neurologic problems.

If your child has a febrile seizure, he or she is at increased risk of having subsequent febrile seizures. Almost half of children who have one febrile seizure have another, and sometimes multiple recurrences. Febrile seizures can also run in families.

Your child will outgrow this tendency between four to five years of age.

DURING A SEIZURE:

1. Stay calm and ease your child onto a soft surface (e.g., a carpeted floor).
2. Lay your child on his side.
3. Try to observe your child's movement and time the length of the seizure.
4. Do NOT restrain your child.
5. Do NOT put anything in your child's mouth.

Your child may be sleepy immediately after the seizure, but behavior should return to normal by hours after the seizure. If your child is not acting normally by two hours after the seizure, call the office or the physician on call.

We recommend treating your child with the appropriate dose of acetaminophen or ibuprofen (see FEVER section for dose) at the earliest sign of fever, although this may not prevent a seizure.

CALL FOR EMERGENCY HELP IF:

- Your child has difficulty breathing and/or is turning blue.
- Your child has a seizure that lasts longer than five minutes.
- Your child is not recovering as expected after a seizure.

CALL THE DOCTOR IMMEDIATELY IF:

- Your child has a seizure for the first time.
- Your child shows signs of meningitis (e.g., fever, neck stiffens or drowsiness).

CALL THE DOCTOR TODAY IF:

- Your child has a febrile seizure—your doctor will want to determine the underlying cause for the fever. See also FEVER section.

Feeding (Infants)

For infants who are nursing, the average number of feedings is eight to 12 times a day. The length of feeds may vary from 20–40 minutes per feeding. Alternate which breast you offer first. During the first week of life, breastfed babies should feed every two hours, and thereafter every two to three hours. Generally, newborn infants feed more frequently than older infants, and breastfed infants feed more frequently than formula-fed infants. Newborn formula fed babies take two to three ounces per feeding every two to three hours. This may lengthen to every four hours by three months of age, and ounces will increase.

If you wish to substitute a bottle for breastfeeding on an occasional basis, we recommend waiting until after the infant is three to four weeks of age to fully establish the breast milk supply. For mothers who will be returning to work and will need to leave the baby but want to continue to nurse, we recommend introducing a bottle at least one month before returning to work. You may use expressed breast milk or formula. If you wish to express milk while at work, you should plan on doing so at least every four hours, or as often as the infant will be having a bottle while you are away to protect your milk supply. You may store expressed breast milk in the refrigerator for four days or freeze it for up to six months.

We do not generally recommend altering the mother's diet while she is nursing. If the infant is exceptionally gassy or irritable, we might recommend a trial elimination of milk products, chocolate, broccoli, cauliflower or other gas-producing foods.

Never give extra water to infants younger than six months old.

Just about any drug you take will get into the breast milk and potentially can affect your baby. Other substances such as alcohol, nicotine and caffeine also enter breast milk. Please check with your doctor first before taking any medications, even OTC medications, while breastfeeding.

We generally do not recommend the introduction of solid foods before six months of age. Formula or breast milk meet all the nutritional needs for babies under six months of age. At six months, solid foods can be introduced. Start with an infant cereal (rice, barley or oatmeal) mixed with formula or breast milk. Introduce vegetables and fruit next. Only add one new food every three days. As soon as a few non-allergenic foods are introduced without reaction, and as long as your baby has no eczema or family history of eczema and has not demonstrated any food allergy, introduce peanuts at six months. This helps to prevent peanut allergy. Add a small amount of peanut butter to other foods. Peanut puffs can also be used. If your child has eczema or has had an allergic reaction to another food, discuss with your doctor when (early is better) and how (usually allergy testing is done first) to introduce peanuts. Other allergenic foods such as egg can also be introduced in a similar manner. Meats and dairy/yogurt are the last foods to be introduced.

At eight to 12 months, mashed soft table foods can be introduced. Finger foods can be introduced when your baby develops a pincer grasp, usually around nine to ten months. Cheerios, soft cheeses, scrambled eggs, bananas and soft canned fruit like peaches and pears are all good choices.

Never give honey in the first year of life. This is to prevent botulism. Never give cow's milk (except as in the formula) in the first year of life—only breast milk or formula.

By one year, your baby should be eating the same foods as your family; just make sure food is cut into very small pieces. Avoid foods that are choking hazards, like grapes, hot dogs, peanuts and popcorn. Avoid raw vegetables. Peanut butter mixed with other foods is fine, but avoid peanut butter alone, as it is thick, sticky and hard to swallow.

Fever (See also FEBRILE SEIZURE)

Fever means a rectal temperature greater than 100.4° F. It is generally not an emergency and can be considered the body's way of fighting an infection. Exercise, excessive clothing, a hot bath or hot weather can cause mild elevation of temperature (up to 101.5° F).

If an infant less than six months of age has a fever, you should call the office. Any fever can be a sign of serious illness in an infant less than three months of age, and you should call immediately, even if after hours.

For older children, the symptoms that accompany fever are of more importance than the fever itself. Symptoms that accompany fever may not appear until 24 hours after the fever starts. Many parents treat low-grade fevers unnecessarily with medication and sponging. Remember that fever is helping your child fight infection.

Use the ranges below to help put your child's level of fever into perspective.

The accompanying table on the next page shows oral acetaminophen and ibuprofen dosages for children. One to two hours after taking them, these drugs will reduce fever by two to three degrees. Repeated doses of the drugs are necessary because the fever will go up and down as the illness runs its course. Remember that fever's response, or lack of response, to medicine tells little about the severity of the infection. If your child is sleeping, don't wake him up to give fever control medications. If the fever is high enough to need medication, your child will awaken.

ADDITIONAL MEASURES TO REDUCE FEVER:

Sponge your child only when necessary. Sponging is usually not necessary to reduce fever. Do not sponge your child without giving acetaminophen first, except in emergencies such as a fever over 106° F. In other cases, sponge your child only if the fever is still over 104° F when you retake the temperature 30 minutes after giving acetaminophen or ibuprofen and your child is still uncomfortable. Until acetaminophen has taken effect, sponging will just cause shivering, which is the body's attempt to raise the temperature.

If you do sponge your child, use lukewarm water (85 to 90° F) or cooler water for emergencies. Sponging works much faster than immersion, so have your child sit in two inches of water and keep wetting the skin surface over the entire body. If your child shivers, raise the water temperature or wait another ten to 20 minutes for the acetaminophen or ibuprofen to take effect. Don't expect to get the temperature below 101° F.

CAUTION: DO NOT ADD RUBBING ALCOHOL to the water, because breathing in the fumes can cause coma.

FEVER CHART

100°–102° F (37.8°–39° C)	102°–104° F (39°–40° C)	104°–105° F (40°–40.6° C)	OVER 105° F (40.6° C)
Low-grade fevers: Helpful. Don't treat.	**Moderate fevers:** Still helpful. Treat if causes discomfort.	**High fevers:** Always treat. Some patients need to be seen.	Less than 1% of fevers go this high. All these patients need to be examined. Always treat the fever.