"Building a Healthy Future"

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Welcome to Peerless Pediatrics

Our Mission Statement

The Physicians and Staff of Peerless Pediatrics commit to provide superior care to your family in a compassionate and timely fashion. We will provide the most current medical care available and pledge to partner with you to grow your child into a healthy adult.

We are pleased to have the privilege of caring for your child. We strive to care for your child as if they were our own. We want to take this opportunity to introduce you to our practice.

Physicians

Dr. Dennis Betts
Dr. Barry Crabtree
Dr. Wayne Kelly
Dr. Brian Coyle
Dr. Stephanie Sanderson
Dr. Matt Workman

Scheduling and Appointments

Because we all lead busy lives and we realize that your time is valuable, we have implemented a process to provide your family with timely and efficient care. We are open Monday – Friday 8:00 a.m. until 6:00 p.m., and Saturday 8:00 a.m. until 12:00 p.m. We will see walk-in patients Monday – Friday from 8:00 a.m. until 8:30 a.m.

Waiting Rooms

The design of our office offers both Well waiting and Sick waiting areas. It is our goal to keep sick children away from well children. We would appreciate your cooperation with this effort. If your child is sick, we ask that you sit in the Sick waiting area to be courteous to other patients. We have intentionally left our waiting area void of any toys or play areas because it is impossible to keep this type of play area germ-free throughout the busy day. Because we are in the business of wellness, we encourage patients to bring a few small toys for their children to play with during their wait time. We have equipped our waiting areas with educational video players. We do not have children's movies because we have found that our patient population enjoys a widely

diverse mix of movies; we do not want to offend anyone, therefore educational information is a good option for our waiting areas.

Walk-In Clinic

We provide walk-in appointments Monday – Friday from 8:00 until 8:30 a.m. to help working parents get sick children seen prior to going to work in the morning.
Due to limited resources in our Saturday clinic, we are unable to see walk-ins. However, if you have a sick child, call us and we will be able to get them in to be seen.

Well Child Checks/Preventative Visits

Each physician has reserved a portion of their schedule specially for well care appointments. We encourage you to schedule your next well care visit at the end of your current visit to ensure proper timing between the appointments. These visits are an important part of your child's physical and developmental well-being; therefore, we make every effort to make these appointments available for you. We ask that you check your insurance benefits ahead of time to ensure that you are aware of what your specific plan will cover with regard to wellness services. Due to the multiple insurance plans available that offer a wide variance in coverage, we are not always able to check these benefits for you. Therefore, we request that you assist us with this endeavor by reviewing individual coverage details of your plan.

Sick Visits

We promise you that we will make every effort to see your sick child the day that you call. However, if your call is not received until late in the day, we may need to schedule your visit for the following morning. All sick children will be seen within 24 hours of the initial phone call to our office. If all of our appointment slots are already taken, we will take a Nurse message so that the illness can be assessed by one of our nurses. We may offer "over-book" appointments if the situation warrants it. There may be times we suggest that the patient be seen the following day, if the condition is not an emergency. All of our nurses are well trained, experience, and response to your child's needs.

Telemedicine Visits

We offer Telemedicine visits for some sick and well visits. Check with us to see if Telemedicine is the right choice for you.

Hospital Care

We are an outpatient pediatric practice and do not visit patients who are in the hospital. We work closely with our local hospitals, Children's Hospital in Chattanooga and East Tennessee Children's in Knoxville; however, in the case of a severe emergency, we advise that you take your child to the nearest hospital possible to obtain medical treatment. While we do not render care to your child during the stay, we are available to the physicians who are treating your child to answer any questions they may have regarding past medical history.

Routine Questions

Our clinical staff is well equipped to answer your questions regarding common illnesses, common medications, and developmental/behavioral issues. We are always happy to assist you if you have issues regarding your child. In addition, our website has a variety of information available for you, from dosage information to our physicians' responses to frequently asked questions. You can find us at

www.peerlesspediatrics.com

After Hours/Emergency calls

We have a physician on call for emergencies only. We work with Children's Hospital at Erlanger to provide after-hours telephone triage service for our patients. This service uses the same emergency protocols that we use in our office and is staffed with experienced pediatric registered nurses. We ask that you limit your after hours calls to **emergency only**. You may be charged a fee of $14 -$19 per after-hours emergency telephone calls.

Missing Appointments

Out of courtesy for other patients, we ask when you are unable to keep your appointment with us, that you cancel within 24 hours of the appointment time if at all possible. If you fail to cancel the appointment, a No-Show fee of $25 could be billed to you. We appreciate your cooperation with our cancellation policy. We will not file this charge with your insurance company; it will be your financial responsibility to be paid before or during your next visit to our office.

Late Arrivals

Out of courtesy for other patients with appointments, if you are running late for an appointment, please call ahead to let us know you will be late. We will make every effort to work you back into the schedule; however, during peak season, we may be forced to reschedule your appointment.

Financial

Our office is happy to file your insurance for you. In order to do so, we ask that you make sure to bring your most recent insurance card to your appointment. We will ask you to update your information sheet **at least once per year.** If your insurance changes at any time, it is your responsibility to provide us with new information. It is important that we have current and accurate information on file. It is our contractual obligation with your insurance company to collet your co-pay/co-insurance/deductible at the time of the visit. If we are unable to collect at the time of the visit, we will add a $15 processing charge to cover our billing expense for monies that were due at the time of service. We accept cash, check, debit card, credit card and Paypal. If you write a check that is returned to us for insufficient funds, your account with us will be charged an additional $20 check fee.

In today's environment, it is impossible for us to be aware of what each individual insurance policy will cover. Our policy is to collect all co-pays, co-insurance, and deductibles at the time of service. Although we collect these amounts before we file your insurance claim, once the claim is filed, there could be a balance due for other reasons. We ask for you to be familiar with your benefit plan to ensure that once your insurance has paid, you will be prepared to pay the difference when you receive our bill. Please note, we will send you a statement. If the statement goes unpaid, you will receive a collection letter indicating your balance owed is past due. If payment is not received and we have had no communication from you, your account will be referred to an outside attorney that specializes in collections. If you have questions regarding your account, please contact our billing department during normal business hours.

Self-Pay Patients

We are aware not everyone has insurance. We have developed a self-pay fee schedule that takes into consideration we are not using resources for insurance filing and follow-up. The fees are geared more toward instant adjudication. If this is an option you would like to pursue, please ask to speak with someone from our billing department.

Divorced Parents

We are not a party to your divorce decree. The parent who accompanies the child to the appointment is responsible for the amount due for that visit: co-pays, co-insurance and deductible. We will provide a print-out and receipt for payment.

Proof of Identity

In order to comply with several new governmental regulations, our practice must now collect proof of identity from each parent. We apologize for any inconvenience this may cause. We will need to see your Driver's License or other photo identification . This information will be entered into our systems for compliance purposes.

Our Goal

It is our goal to make your visit to our office a pleasant one. We believe by introducing ourselves, our mission statement and our policies, you will find it easier to partner with us for all your child's healthcare needs. We thank you for your confidence in us and allowing us to take care of your most precious asset – your child.

www.peerlesspediatrics.com

With our web-based patient portal, you can simply and securely

- Fill out registration forms
- Pay your bill online
- Find answers to the most frequently asked questions

It's fast, easy, and convenient!

Visit our website for more information and to start using these time-saving capabilities today!

Infant Feeding Chart (age in Months)

FOODS	0-3 MONTHS	4-7 MONTHS	8-12 MONTHS
Breast milk or formula for baby's first year and beyond	Breastfeed frequently (i.e. every 2-4 hours) up to 32 fl oz per day	Breastfeed on demand 27-40 fl oz per day	Breastfeed on demand 24-32 fl oz per day
Cereals and Breads	NONE	Iron fortified single grain cereal, starting with rice at 4-5 months (mixed with formula, breast milk, or water). Feed with a spoon. Wait until baby can sit up before teething biscuits.	Oatmeal, wheat, mixed cereal, crackers, toast, oat rings, rice, pasta.
Fruit Juices	NONE	Infant 100% fruit juice (apple, pear, etc). No citrus or tomato. Offer juices from a cup	100% fruit juices. Citrus such as tomato or orange juice may be included
Fruits and Vegetables	NONE	Wait until 5th month. Offer cooked, strained/mashed mild tasting vegetables: squash, carrots, green beans, pease. Both vegetables and fruits should be given daily. No added salt or sugar.	May begin with soft, raw fruits and soft cooked vegetables or potatoes. No added salt or sugar.
Protein Foods	NONE	NONE	Ground or finely cut meat or poultry. Use lean meat. No fat or bones.

GENERAL GUIDELINES

- Feed only breast milk or formula for the first 4-6 months.
- Do NOT give honey to a child under 1 year of age.
- Introduce only one new food per week to make sure the baby tolerates it.
- When you begin solid stay with breastmilk or formula your doctor recommended if the new food causes a reaction, you will know it was not the formula.
- Do not feed cereal or solids from a bottle.
- Feed solids with the spoon, preferably from a bowl, not the jar, and discard leftovers.
- Some nutritionists advised starting vegetables before fruits to avoid creating a “sweet tooth.”
- Avoid overfeeding. Stop feeding when the baby turns away or shows disinterest.
- Do not give sugar, salt, candy, deserts or soda pop.
- A child should be sitting up and never leave unattended while eating finger foods.
- Do not use cow's milk as a replacement for breast milk or formula during the baby's first year and beyond.
  After that, use whole milk. Do not use 2% or skim milk until the baby is at least 2 years old.
- If the baby is on soy formula, check with the doctor before introducing dairy products.
- Until your child is at least 4 years old and supervised, avoid foods which may cause choking. This includes nuts, raisins, popcorn, candy and hard round food such as chunks of raw carrots, grapes or hot dogs.

BREASTFEEDING FOODS TO AVOID

Gassy foods, such as cabbage, onions, garlic, broccoli, turnips, and beans may cause some problems for some breastfed infants. Usually with food reactions, these types of symptoms last less than 24 hours, and they disappear until the next time they are eaten.

Caffeine or chocolate are another source of food that sometimes create problems for breastfeeding infants. These can cause an infant to be irritable and feed more frequently than usual because infants do not eliminate caffeine from their bodies very efficiently, it tends to build up in their systems. Consequently, you may not notice any reaction in your baby until two or three weeks after birth. Caffeine is found in coffee, soft drinks, chocolate cacao, and even some herbal teas. They may also be found in some over-the-counter medication.

Some foods infants may be allergic to include dairy products, peanuts, eggs, soy protein, fish, meat, and citrus fruits. Symptoms to monitor for are colicky symptoms such as: strong gastrointestinal discomfort, causing baby to draw legs up in pain; inconsolable crankiness or fussiness – often interfering with sleep, and vomiting or diarrhea. Sometimes, the respiratory system may be affected and the baby may have chronic nasal stuffiness, runny nose, cough, please, or difficulty breathing. The allergy also may cause eczema, hives, swelling, itching or rash around the mouth and chin due to the milk. If you suspect your baby has an allergy, please tell your pediatrician.

Normal Development: Newborn

Here's what you might see your baby doing between the ages of 0 and 2 weeks old.

Reflexes

- Reflexive actions: crying, grasping, yawning, swallowing, sucking, blinking, coughing, gagging, sneezing.
- Grasps whatever is placed in hand.
- Sucks whatever is placed in mouth.
- Is startled by sudden noises and movements.

Movement

- Jerky, mostly uncontrolled motions.
- Waves arms, kicks legs, wiggles, and squirms.
- Cannot turn body or support head without assistance.
- May turn head from side to side while lying on back.

Sleep/Wakefulness

- Usually sleeps from 17 to 20 hours per day.
- Cries and fusses about 1 to 4 hours per day.
- Is alert and quiet about 2 to 3 hours per day.

Vision

- Cannot focus clearly.
- Sees best at 8 to 10 inches.

Interactive Behaviors and Senses

- Smiles spontaneously and unselectively.
- Discriminates between some smells.
- Begins to turning direction of sound.
- Begins to distinguish the human voice from other sounds.
- Is more sensitive to high-pitched voices, especially mother's voice.
- Is best calmed by a soft, rhythmic voice.
- Cries a lot.
- Makes tiny gurgling sounds when content.
- Shows preference for the human face.

Each child is unique. It is difficult to describe exactly what should be expected at each stage of a child's development. While certain behaviors and physical milestones tend to occur at certain ages, a wide range of growth and behavior for each age is normal. These guidelines show general progress through the developmental stages rather than fixed requirements for normal development at specific ages. It is perfectly natural for a child to reach some milestones earlier and other milestones later than the general trend.

Normal Development: 2 Weeks Old

Here's what you might see your baby doing between the ages of 2 weeks and 2 months.

Movement

- Movements gradually become smoother and more controlled.
- Lifts chin for a few seconds when lying on tummy.
- Cannot support head without assistance.
- Grasps whatever is placed in hand.

Vision and Hearing

- May follow some moving objects with eyes.
- Explores surroundings with eyes.
- Turns indirection of some sounds.

Interactive Behaviors

- Cries to express specific things, such as hunger, pain, being too hot or too cold, and excitement.
- May cry when left alone; usually stops when picked up.
- Makes variety of gurgling and cooing sounds when happy and content.
- Mayes eye contact.
- May quiet down in response to human face.
- Responds positively to being held and comforted.
- May smile socially at familiar faces and voices, especially mother's voice.

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Normal Development: 2 Months Old

Here's what you might see your baby doing between the ages of 2 and 4 months.

Daily Activities

- Crying gradually becomes less frequent.
- Shows greater variety of emotions: distress, excitement, delight.
- Sleeps for longer periods during the night.
- Smiles, gurgles, and coos, particularly when talked to.
- Shows more distress when an adult leaves.
- Quiets down when held or talked to.
- Does not think things exist if they cannot be seen, touched, or tasted.

Vision

- Focuses better, but still no more than 12 inches.
- Follows objects by moving head from side to side.
- Prefers things that are brightly colored.

Hearing

- Knows the difference between male and female voices.
- Knows the difference between angry and friendly voices.

Motor Skills

- Moves more smoothly.
- Lifts chest for a short time when lying on tummy.
- Holds head steady when held or seated with support.
- Discovers hands and fingers.
- Grasps with more control.
- May bat at dangling objects with entire body.

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Normal Development: 4 Months Old

Here's what you might notice your baby doing between the ages of 4 months and 6 months of age.

Daily Activities

- Is active, playful, and likes people.
- Reaches and grasps some objects.
- Shakes rattle when placed in hand.
- Carefully studies objects placed in hand.
- Puts everything into mouth.
- Plays contentedly with fingers and hands.
- Usually sleeps through the night.
- Laughs and giggles while playing and socializing.
- Basks in attention.
- Just begins to realize objects exist even when out of sight.

Hearing

- Turns head in response to human voice.
- Smiles and coos when talked to.

Motor Skills

- Rolls from front to back.
- Holds up chest when lying on tummy.
- Supports head when held in sitting position.
- Sits with support for longer periods.
- Enjoys using the legs in kicking motions

Vision

- Focuses clearly.
- Fascinated with mirror image.

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Normal Development: 6 Months Old

Here's what you might see your baby doing between 6 and 9 months of age.

Daily Activities

- Adores playing with rattles and squeaky toys.
- Sleeps through the night.
- Usually begins teething.
- May prefer some foods to others.
- May enjoy playing with food.
- Loves games like peek-a-boo and pat-a-cake.

Language Development

- Babbles and squeals using single syllables.
- Loves to jabber.
- May recognize own name.

Emotional Development

- May show sharp mood changes.
- Displays especially strong attachment to mother.
- Develops deeper attachment to father, siblings, and other familiar people.
- Distinguishes children from adults.
- Smiles at other children.
- May show fear of strangers.
- Continues to be intrigued with mirror image.

Motor Skills

- Rests on elbows.
- Begins to sit alone.
- Sits in high chair.
- Continues to use motions leading to crawling.
- Makes jumping motions when held in standing position.
- Reaches with one hand.
- Bats and grasps dangling objects.
- Holds objects between thumb and forefinger.
- Passes objects from one hand to another.

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Normal Development: 9 Months Old

Here's what you might see your baby doing between the ages of 9 and 12 months.

Daily Activities

- Continues to enjoy banging, waving, and throwing toys.
- Scrutinizes toys and other objects.
- Becomes absorbed in toys and games.
- Explores food with fingers.
- Initiates play.

Motor Skills

- Goes from sitting to lying position unassisted.
- May pull self to standing position.
- Stands holding on to furniture.
- Tries to move one foot in front of the other when held upright.
- May try to crawl up stairs.
- May begin to walk with assistance.

Language Development

- Imitates the rising and falling sounds of adult conversation.
- Imitates more speech sounds, but does not yet understand most of them.
- Repeats sounds again and again.
- May begin to say "mama" and "dada" appropriately.

Emotional and Behavioral Development

- Continues to resist doing what he does not want to do.
- Begins trying to imitate some parent behaviors.
- Loves showing off for family audience.
- May cry when parent leaves the room.
- May resist diapering.

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Normal Development: 12 Months Old

Here's what you might see your baby doing between 12 months and 15 months old.

Daily Activities

- Usually has a definite daily pattern.
- Opens cabinets, pulls tablecloths.
- Usually examines an object before putting into mouth.
- Likes to feed self.

Language Developmen

- Expresses complete thought with single syllable ("da" means "I want that").
- Shows definite understanding of a few simple words.
- Says a few words ("mama", "dada", "ball", "dog").
- Loves rhythms and rhymes.

Emotional and Behavioral Development

- Shows more negativism (may resist naps, refuse certain foods, throw occasional tantrums).
- Continues to prefer people to toys.
- Has developed a deep attachment to a few familiar people
- Loves to make parents laugh.
- Shows somewhat less stranger anxiety.
- May give up something on request.

Motor Skills

- Usually walks with assistance; may walk without assistance.
- Crawls rapidly.
- Stands alone.
- Seats self on floor.

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Normal Development: 15 Months Old

Here's what you might see your child doing between the ages of 15 and 18 months.

Daily Activities

- Avidly explores everything.
- Revels in water play.
- Likes to feed self.
- Begins to use more objects conventionally (for example, may put comb in hair).
- Enjoys throwing, rolling, pushing, pulling toys.

Motor Skills

- Stands unsupported.
- Walks without assistance with wide stance and outstretched arms.
- Climbs stairs with assistance.
- Refines grasp.
- Picks up objects from a standing position.

Language Development

- Knows several words.
- Adds gestures to speech.
- Prefers adults to other children.
- Likes to watch and imitate activities.

Cognitive Development (Thinking and Learning)

- Looks to parent for help in solving problems.
- Learns cause-effect relationship (repeats enjoyable actions).
- Looks for hidden objects in last place seen.
- Begins to experiment through trial and error.

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Normal Development: 18 Months Old

Here's what you might see your child doing between the ages of 18 and 24 months.

Daily Activities

- Begins to eat with fork.
- Enjoys imitating parents.

Motor Skills

- Walks skillfully.
- Enjoys pushing and pulling toys while walking.
- Runs awkwardly and falls a lot.
- Walks backward a short distance.

Cognitive Development (Thinking and Learning)

- Understands that something can exist even when hidden.
- Can picture objects and events mentally.

Language Development

- Speaks from 3 to 50 words.
- Wants to name everything.
- May use a few two-word combinations.
- Repeats familiar and unfamiliar sounds and gestures.

Emotional and Behavioral Development

- May begin to show frustration when not understood.
- May show strong attachment to a toy or blanket.
- May resist bedtime, prefers predictable pattern of bedtime events.
- May respond with "no" constantly.
- Likes to show some independence (feds self, undresses self).
- Begins to develop a self-concept.
- Responds to simple requests ("Bring me your book.").

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Normal Development: 2 Years Old

Physical Development

- Is always in motion.
- Tires easily.
- Runs and climbs.
- Walks up and down stairs alone.
- Starts to walk on tiptoes.
- Goes from random scribbling to somewhat more controlled movements.
- Can button and unbutton large buttons.
- Develops greater independence in toileting needs (still needs some help).
- May have trouble settling down for bedtime.
- Primary teeth finish coming in.

Emotional Development

- Gets upset and impatient easily.
- Shows anger by crying or striking out.
- Gets frustrated when not understood.
- Wants own way.
- May assert self by saying "no."
- Goes back to acting like a baby at times.
- Is upset when daily routine changes.
- Has sharp mood changes.

Social Development

- Likes to imitate others.
- Gets more interested in brothers and sisters.
- Knows gender.
- May have an imaginary playmate.
- Enjoys playing among, not with, other children.
- Does not share.
- Claims everything is "mine."
- May scratch, hit, bite, and push other children.

Mental Development

- Is much more interested in language.
- Uses 3- to 5-word phrases by end of second year.
- Understands more words than can speak.
- Likes to "do-it-myself."
- Can build a tower of 3 to 5 blocks.
- Cannot be reasoned with much of the time.
- Cannot make choices.

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Going Home from the Hospital with Your New Baby

Most hospitals will discharge you and your baby within forty-eight hours if you have delivered vaginally. However, if you undergo a Cesarean section, you may stay at the facility for four to five days. If your baby is born in an alternative birthing center, you may be able to go home within twenty-four hours. Nevertheless, just because a full-term, healthy infant *could* be discharged from the hospital in less than forty-eight hours doesn't mean it should necessarily occur.

The American Academy of Pediatrics believes that the health and well-being of the mother and her child is paramount. Since every child is different, the decision to discharge a newborn should be made on a case-by-case basis. If a newborn does leave the hospital early, he or she should be seen by a doctor twenty-four to forty-eight hours after discharge.

Prior to making the decision about when to go home, you and your doctor need to weigh the advantages and disadvantages carefully. From an emotional and physical standpoint, there are arguments for both a short (one to two days) and a longer (three-plus days) stay. Some women simply dislike being in the hospital and feel more comfortable and relaxed at home; as soon as they and their baby are proclaimed healthy and able to travel, they're eager to leave. By keeping the hospital stay short, they'll certainly save themselves—or their insurance company—money. However, many new mothers often cannot get as much rest at home as in the hospital—especially if there are older children clamoring for attention. Nor are they likely to have access to the valuable support that trained nurses can offer in the hospital during the first days of breastfeeding and baby care.

If a newborn does leave the hospital early, he should have received all the appropriate newborn tests such as a hearing screen, and he also should be seen by the pediatrician twenty-four to forty-eight hours *after* discharge. Of course, the doctor should be called immediately whenever a newborn appears listless or is feverish, is vomiting, has difficulty feeding, or develops a yellow color to his skin (jaundice).

Before you do leave the hospital, your home and car should be equipped with at least the bare essentials. Make sure you have a federally approved car safety seat that is appropriate for your baby's size, and which you have correctly installed rear-facing in the backseat of your vehicle. It is extremely important to follow the car seat manufacturer's instructions on installation and proper use carefully, and if possible, it is helpful to get your car seat installation checked by a certified child passenger safety technician to ensure that you've gotten it right.

At home you'll need a safe place for the baby to sleep, plenty of diapers, and enough clothing and blankets to keep him warm and protected. If you're formula-feeding, you'll also need a supply of formula.

Bringing Baby Home: How to Prepare for the Arrival of Your Newborn

One of the most cautious drives you'll ever take is the one bringing your baby home with you. Newborns look and feel fragile, and they represent a new of world of uncertainty. Here's what you need to know to make your transition to parenthood easier.

It's true: There's no official instruction manual for becoming a parent.

But relax. You're not the first parent to wonder why you've been entrusted with a little person without an instruction manual. The 40 weeks (give or take) of pregnancy allow time for more than just picking out names; it's your opportunity to plan and prepare. The more you know about your newborn, the better equipped you'll be when she arrives.

Once your baby is born, doctors will be looking for a few key signs that she is healthy and ready to go home, says Vinod K. Bhutani, M.D., FAAP, professor of pediatrics at Lucile Packard Children's Hospital at Stanford University School of Medicine. "First they will want to see that the baby is able to breathe well and maintain her body temperature," says Dr. Bhutani, who is also a member of the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn.

Newborns must also demonstrate that they can feed well. Regardless of whether she's breastfed or bottle-fed, all babies should be wetting at least three or four diapers in a 24-hour period, says Dr. Bhutani. And while many newborns have some jaundice — a yellowish tint to their skin — their jaundice will be evaluated before they're sent home from the hospital. If necessary, your pediatrician will discuss a follow-up plan for monitoring your baby's jaundice.

Healthy at Home

Most healthy newborns go home after two or three days, yet the transition for parents is just beginning. "It's OK to be a little scared — the first week after babies are born is when they're most vulnerable," says Dr. Bhutani. "Newborns can have multiple medical problems that if left unattended can become serious."

Dehydration is sometimes a concern for newborn babies that can continue once they've left the hospital. Your pediatrician will discuss dehydration with you so you'll know what to look for, how to respond, etc.

Parents should also watch for signs of infection in their newborn. Infections can be picked up during birth or from people other than the parents handling the baby, such as visitors. "Most people think only of fevers, but newborns can have dropping temperatures or a low temperature that's of concern," says Dr. Bhutani. It's always wise to watch for signs of infection around the belly button or circumcised foreskin, such as poor sucking during breastfeeding, a lack of appetite, poor weight gain, weak crying, and increasing irritability.

Jaundice happens in most every baby, peaking in the first week as newborns learn to excrete the yellow pigment called bilirubin in their stools. "Babies tend to have slow liver function at first

and may have some evidence of jaundice as their livers quickly mature over the first several days," write Drs. Laura Jana and Jennifer Shu in Heading Home With Your Newborn. "The bilirubin level generally peaks by about 5 days for term babies and about 1 week for those born prematurely." If your baby continues to have signs of jaundice — very yellowish skin and eyes — after day four, consult your pediatrician.

Although most babies remain perfectly healthy after they're discharged from the hospital, it's important to watch for any signs of illness and take your child to the pediatrician for evaluation within a day or two of leaving the hospital. "Every baby needs to be seen by a pediatrician on day three, four, or five," says Dr. Bhutani. "It's a must."

Quick Tips: Time to Call the Doctor

Watch for these signs that it's time to call your pediatrician:

- Your newborn's breathing is faster or irregular
- You notice blueness or a darkness on the lips or face
- Your newborn has a fever
- Your newborn's body temperature has dropped
- You see signs of dehydration (less than 3 to 4 wet diapers in a 24-hour period)
- Your baby's belly button or circumcision area looks infected
- Your newborn's jaundice does not decrease by the fifth day
- Your baby is crying a lot or appears sluggish
- You think your baby is not looking or feeling well

Baby's First Days: Bowel Movements & Urination

Urination

Your baby may urinate as often as every one to three hours or as infrequently as four to six times a day. If she's ill or feverish, or when the weather is extremely hot, her usual output of urine may drop by half and still be normal. Urination should never be painful. If you notice any signs of distress while your infant is urinating, notify your pediatrician, as this could be a sign of infection or some other problem in the urinary tract.

In a healthy child, urine is light to dark yellow in color. (The darker the color, the more concentrated the urine; the urine will be more concentrated when your child is not drinking a lot of liquid.) Sometimes you'll see a pink stain on the diaper that you may mistake for blood. In fact, this stain is usually a sign of highly concentrated urine, which has a pinkish color. As long as the baby is wetting at least four diapers a day, there probably is no cause for concern, but if the pinkish staining persists, consult your pediatrician.

The presence of actual blood in the urine or a bloody spot on the diaper is never normal, and your pediatrician should be notified. It may be due to nothing more serious than a small sore caused by diaper rash, but it also could be a sign of a more serious problem. If this bleeding is accompanied by other symptoms, such as abdominal pain or bleeding in other areas, seek medical attention for your baby immediately.

Bowel Movements
Beginning with the first day of life and lasting for a few days, your baby will have her first bowel movements, which are often referred to as meconium. This thick black or dark-green substance filled her intestines before birth, and once the meconium is passed, the stools will turn yellow-green.

If your baby is breastfed, her stools soon should resemble light mustard with seed like particles. Until she starts to eat solid foods, the consistency of the stools may range from very soft to loose and runny. If she's formula-fed, her stools usually will be tan or yellow in color. They will be firmer than in a baby who is breastfed, but no firmer than peanut butter.

Whether your baby is breastfed or bottle-fed, hard or very dry stools may be a sign that she is not getting enough fluid or that she is losing too much fluid due to illness, fever, or heat. Once she has started solids, hard stools might indicate that she's eating too many constipating foods, such as cereal or cow's milk, before her system can handle them. (Whole cow's milk is not recommended for babies under twelve months.)

Here are some other important points to keep in mind about bowel movements:

- Occasional variations in color and consistency of the stools are normal. For example, if the digestive process slows down because the baby has had a particularly large amount of cereal that day or foods requiring more effort to digest, the stools may become green; or if the baby is given supplemental iron, the stools may turn dark brown. If there is a minor irritation of the anus, streaks of blood may appear on the outside of the stools. However, if there are large amounts of blood, mucus, or water in the stool, call your pediatrician immediately. These symptoms may indicate an intestinal condition that warrants attention from your doctor.
- Because an infant's stools are normally soft and a little runny, it's not always easy to tell when a young baby has mild diarrhea. The telltale signs are a sudden increase in frequency (to more than one bowel movement per feeding) and unusually high liquid content in the stool. Diarrhea may be a sign of intestinal infection, or it may be caused by a change in the baby's diet. If the baby is breastfeeding, she can even develop diarrhea because of a change in the mother's diet.

- The main concern with diarrhea is the possibility that dehydration can develop. If fever is also present and your infant is less than two months old, call your pediatrician. If your baby is over two months and the fever lasts more than a day, check her urine output and rectal temperature; then report your findings to your doctor so he can determine what needs to be done. Make sure your baby continues to feed frequently. As much as anything else, if she simply looks sick, let your doctor know.

The frequency of bowel movements varies widely from one baby to another. Many pass a stool soon after each feeding. This is a result of the gastrocolic reflex, which causes the digestive system to become active whenever the stomach is filled with food.

By three to six weeks of age, some breastfed babies have only one bowel movement a week and still are normal. This happens because breastmilk leaves very little solid waste to be eliminated from the child's digestive system. Thus, infrequent stools are not a sign of constipation and should not be considered a problem as long as the stools are soft (no firmer than peanut butter), and your infant is otherwise normal, gaining weight steadily, and nursing regularly.

If your baby is formula-fed, she should have at least one bowel movement a day. If she has fewer than this and appears to be straining because of hard stools, she may be constipated. Check with your pediatrician for advice on how to handle this problem.

Common Conditions in Newborns
Some physical conditions are especially common during the first couple of weeks after birth. If you notice any of the following in your baby, contact your pediatrician.

Abdominal Distension – Most babies' bellies normally stick out, especially after a large feeding. Between feedings, however, they should feel quite soft. If your child's abdomen feels swollen and hard, and if he has not had a bowel movement for more than one or two days or is vomiting, call your pediatrician. Most likely the problem is due to gas or constipation, but it also could signal a more serious intestinal problem.

Birth Injuries – It is possible for babies to be injured during birth, especially if labor is particularly long or difficult, or when babies are very large. While newborns recover quickly from some of these injuries, others persist longer term. Quite often the injury is a broken collarbone, which will heal quickly if the arm on that side is kept relatively motionless. Incidentally, after a few weeks a small lump may form at the site of the fracture, but don't be alarmed; this is a positive sign that new bone is forming to mend the injury.
Muscle weakness is another common birth injury, caused during labor by pressure or stretching of the nerves attached to the muscles. These muscles, usually weakened on one side of the face or one shoulder or arm, generally return to normal after several weeks. In the meantime, ask your pediatrician to show you how to nurse and hold the baby to promote healing.

Blue Baby – Babies may have mildly blue hands and feet, but this may not be a cause for concern. If their hands and feet turn a bit blue from cold, they should return to pink as soon as they are warm. Occasionally, the face, tongue, and lips may turn a little blue when the newborn is crying hard, but once he becomes calm, his color in these parts of the body should quickly return to normal. However, persistently blue skin coloring, especially with breathing difficulties and feeding difficulties, is a sign that the heart or lungs are not operating properly, and the baby is not getting enough oxygen in the blood. Immediate medical attention is essential.

Coughing – If the baby drinks very fast or tries to drink water for the first time, he may cough and sputter a bit; but this type of coughing should stop as soon as he adjusts to a familiar feeding routine. This may also be related to how strong or fast a breastfeeding mom's milk comes down. If he coughs persistently or routinely gags during feedings, consult the pediatrician. These symptoms could indicate an underlying problem in the lungs or digestive tract.

Excessive Crying – All newborns cry, often for no apparent reason. If you've made sure that your baby is fed, burped, warm, and dressed in a clean diaper, the best tactic is probably to hold him and talk or sing to him until he stops. You cannot "spoil" a baby this age by giving him too much attention. If this doesn't work, wrap him snugly in a blanket.

You'll become accustomed to your baby's normal pattern of crying. If it ever sounds peculiar—for example, like shrieks of pain—or if it persists for an unusual length of time, it could mean a medical problem. Call the pediatrician and ask for advice.

Forceps Marks – When forceps are used to help during a delivery, they can leave red marks or even superficial scrapes on a newborn's face and head where the metal pressed against the skin. These generally disappear within a few days. Sometimes a firm, flat lump develops in one of these areas because of minor damage to the tissue under the skin, but this, too, usually will go away within two months.

Jaundice – Many normal, healthy newborns have a yellowish tinge to their skin, which is known as jaundice. It is caused by a buildup of a chemical called bilirubin in the child's blood. This occurs most often when the immature liver has not yet begun to efficiently do its job of removing bilirubin from the bloodstream (bilirubin is formed from the body's normal breakdown of red blood cells). While babies often have a mild case of jaundice, which is harmless, it can become a serious condition when bilirubin reaches what the pediatrician considers to be a very high level. Although jaundice is quite treatable, if the bilirubin level is very high and is not treated effectively, it can even lead to nervous system or brain damage in some cases, which is why the condition must be checked for and appropriately treated. Jaundice tends to be more common in newborns who are breastfeeding, most often in those who are not nursing well; breastfeeding mothers should nurse at least eight to twelve times per day, which will help produce enough milk and help keep bilirubin levels low.

Jaundice appears first on the face, then on the chest and abdomen, and finally on the arms and legs in some instances. The whites of the eyes may also be yellow. The pediatrician will examine the baby for jaundice, and if she suspects that it may be present—based not only on the amount of yellow in the skin, but also on the baby's age and other factors—she may order a skin or blood test to definitively diagnose the condition. If jaundice develops before the baby is twenty-four hours old, a bilirubin test is *always* needed to make an accurate diagnosis. At three to five days old, newborns should be checked by a doctor or nurse, since this is the time when the bilirubin level is highest; for that reason, if an infant is discharged before he is seventy-two hours old, he should be seen by the pediatrician within two days of that discharge. Some newborns need to be seen even sooner, including:

- Those with a high bilirubin level before leaving the hospital
- Those born early (more than two weeks before the due date)
- Those whose jaundice is present in the first twenty-four hours after birth
- Those who are not breastfeeding well

- Those with considerable bruising and bleeding under the scalp, associated with labor and delivery
- Those who have a parent or sibling who had high bilirubin levels and underwent treatment for it

When the doctor determines that jaundice is present and needs to be treated, the bilirubin level can be reduced by placing the infant under special lights when he is undressed—either in the hospital or at home. His eyes will be covered to protect them during the light therapy. This kind of treatment can prevent the harmful effects of jaundice. In infants who are breastfed, jaundice may last for more than two to three weeks; in those who are formula-fed, most cases of jaundice go away by two weeks of age.

Lethargy and Sleepiness
Every newborn spends most of his time sleeping. As long as he wakes up every few hours, eats well, seems content, and is alert part of the day, it's perfectly normal for him to sleep the rest of the time. But if he's rarely alert, does not wake up on his own for feedings, or seems too tired or uninterested to eat, you should consult your pediatrician. This lethargy—especially if it's a sudden change in his usual pattern—may be a symptom of a serious illness.

Respiratory Distress
It may take your baby a few hours after birth to form a normal pattern of breathing, but then he should have no further difficulties. If he seems to be breathing in an unusual manner, it is most often from blockage of the nasal passages. The use of saline nasal drops, followed by the use of a bulb syringe, are what may be needed to fix the problem; both are available over the counter at all pharmacies.
However, if your newborn shows any of the following warning signs, notify your pediatrician immediately:

- Fast breathing (more than sixty breaths in one minute), although keep in mind that babies normally breathe more rapidly than adults.
- Retractions (sucking in the muscles between the ribs with each breath, so that her ribs stick out)
- Flaring of her nose
- Grunting while breathing
- Persistent blue skin coloring

Pigmented Spots & Birthmarks in Newborns
Did you know at least 2% of all babies are born with a small pigmented spot somewhere on their body? These spots are known as a **congenital melanocytic nevus**. In a nutshell, a nevus is a birthmark. Melanocytic means that it is pigment-based; Melanin is the pigment found in human skin.

If you notice a pigmented spot on your baby, be sure to show it to your child's pediatrician at his or her next visit. Your pediatrician can identify any spots that would require further testing or ones that are nothing to worry about.

Types of Pigmented Spots in Newborns

Café-au-lait spots

- Café-au-lait spots are flat, light tan or light brown spots that are usually shaped like an oval. The skin is normal texture, and the spots do not pose any risk to your child. If your child has a lot of these spots that are larger than a quarter, you should discuss it you're your child's pediatrician as it can be a marker of other diseases.

Mongolian Spot

- Mongolian spots are very common in darker skinned babies. They are flat, bluish-gray colored *(almost looking like a bruise).* They are most commonly found on the lower back and buttocks, and sometimes on the shoulder. Most of them fade somewhat by the time a child reaches age two and have completely disappeared by age five. If Mongolian spots remain at puberty, they are likely to be permanent.

Congenital Melanocytic Nevi

- **Congenital melanocytic nevi** are moles that are present at birth. They are divided into categories depending on their size.
- **Small nev**i *(less than 3 inches in diameter)* are common, occurring in about 1% of all newborns. They tend to grow with the child and usually don't cause any problems. Rarely, however, these moles may develop into a type of serious skin cancer at some later time.
- **Larger congenital nevi** (3 inches to the size of a book) might be flat or raised, may have hair growing from it, and can be so large that it covers an arm or a leg. Fortunately, these nevi are very rare *(occurring in 1 out of every 20,000 births)*. Larger congenital nevi have a greater risk of developing into skin cancer than do smaller congenital nevi. It's a good idea to watch them carefully and have them checked by your pediatrician regularly. If there is any change in the mole's *appearance (color, size, or shape),* your pediatrician may refer you to a pediatric dermatologist who will advise you on removal and any follow-up care.

Vascular malformations and hemangiomas

- These are a varied group of normally colored or pigmented spots that can be raised or flat and represent a growth of normal or abnormal blood vessels. Hemangiomas in infants *(often referred to as strawberry hemangiomas)* can develop anytime in the first few months of life. They are present in about 10% of infants at one year of age tend to disappear before school age.

Nevus sebaceous

- This is a waxy, yellow-orange, hairless skin spot that is usually found on the head and face. These spots are an overgrowth of the top layer of skin along with hair follicles and glands. By the time a child reaches puberty, these spots often become more irritated and raised. There is also a small risk of these skin lesions changing into a skin cancer during puberty. Typically, surgical removal is recommended by adolescence.

Questions from Parents

My child has a birthmark that I think should be removed for cosmetic reasons. Who should I talk to?

There are many reasons to remove skin spots, including those that may be disfiguring or cosmetically unacceptable. There are also types of skin spots that go away with time, or respond to non-surgical treatments. The first person to talk to would be your child's pediatrician. He or she can advise you on the best course of action. If your pediatrician agrees that the spot should be removed, he or she can refer you to a pediatric specialist who can safely remove the spot.

What types of doctors take care of children with skin spots at birth?

Pediatricians are trained to recognize all of the most common types of pigmented spots or birthmarks that children have. They will help guide you to the management of these spots and can refer to other pediatric specialists if needed.

- **Pediatric dermatologists** are specialists in all types of skin problems, including pigmented spots. They also may be asked to help in the diagnosis and treatment of skin conditions.
- **Pediatric plastic surgeons** are trained in the removal of skin spots in cosmetically sensitive areas such as the face, and also are trained in the removal of challenging or large skin spots.

A combination of these types of doctors may be involved in your child's care if needed.

What warning signs should I look for?

If any skin spot concerns you, it should be discussed with your doctor.

- A spot that changes color, texture, or appearance
- A spot that appears to be growing
- A spots that bleeds

Rashes in Newborns

Diaper Rashes

Diaper rash is the term used to describe a rash or irritation in the area covered by the diaper. The first sign of diaper rash is usually redness or small bumps on the lower abdomen, buttocks, genitals, and thigh folds—surfaces that have been in direct contact with the wet or soiled diaper.

This type of diaper rash is rarely serious and usually clears in three or four days with appropriate care. The most common causes of diaper rash include:

1. Leaving a wet diaper on too long. The moisture makes the skin more susceptible to chafing. Over time, the urine in the diaper decomposes, forming chemicals that can further irritate the skin.
2. Leaving a stool-soiled diaper on too long. Digestive agents in the stool then attack the skin, making it more susceptible to a rash.

Regardless of how the rash begins, once the surface of the skin is damaged, it becomes even more vulnerable to further irritation by contact with urine and stool and to subsequent infection with bacteria or yeast. Yeast infections are common in this area and often appear as a rash on the thighs, genitals, and lower abdomen, but they almost never appear on the buttocks.

Although most babies develop diaper rash at some point during infancy, it happens less often in babies who are breastfed (for reasons we still do not know). Diaper rash occurs more often at particular ages and under certain conditions:

- Among babies eight to ten months old
- If babies are not kept clean and dry
- When babies have diarrhea
- When a baby starts to eat solid food (probably due to changes in the digestive process caused by the new variety of foods)
- When a baby is taking antibiotics (because these drugs encourage the growth of yeast organisms that can infect the skin)

Symptoms of Diaper Rash

- Mild rashes just have areas of pink, dry skin.
- Severe rashes have areas of red skin. In some areas, the skin may become raw or even bleed.
- Pink rashes are not painful, but raw ones can be very painful. This can lead crying and poor sleep.

Prevention of Recurrent Diaper Rash

- Change the diaper as soon as possible after a bowel movement. Cleanse the diaper area with a soft cloth and water after each bowel movement. Avoid using diaper wipes which may irritate the skin further. You want to avoid skin contact with stool as much as possible and avoid prolonged exposure to moisture from wet diapers.
- Expose the baby’s bottom to air whenever feasible. When using plastic pants or disposable diapers with tight gathers around the abdomen and legs, make sure air can circulate inside the diaper.
- Be sure to clean stool off all the skin folds. Cleaning the scrotum can be a challenge.

If a diaper rash develops in spite of your efforts, begin using an oil-based barrier (ointment) to prevent further irritation from the urine or stool. The rash should improve noticeably within forty-eight to seventy-two hours. If it doesn't, consult your pediatrician.

Different Types of Diaper Rash

- **Irritant Diaper Rash.** Mild rashes can be caused by the drying effect of soaps.
- **Stool Diaper Rash.** Stool left on the skin can be very irritating because it contains bacteria. Urine alone has no germs in it and usually doesn't irritate the skin. This rash is common on the scrotum or anywhere that stool can hide. Small ulcers around the anus are often from prolonged stool contact.
- **Ammonia Diaper Rash**. Stool and urine left in diaper too long can combine to make ammonia. It can cause a mild chemical burn. The fumes when you change the diaper will smell like ammonia. This is more common with cloth diapers.
- **Diarrhea Diaper Rash**. Rashes just found around the anus are common during bouts of diarrhea. Diarrhea stools also contain enzymes that digest food and irritate the skin.
- **Yeast Diaper Rash.** Rashes from irritants can get a secondary infection with yeast. Yeast infections are bright red. They can be raw and weepy. The borders are sharp. Small red bumps or even pimples may occur just beyond the border. If treated correctly, a diaper rash should be cured in 3 days. If not, it has probably been invaded by yeast. Treat with an anti-yeast cream.
- **Bacterial Diaper Rash.** Bacteria can also cause a secondary infection of irritated skin. This is less common than yeast rashes. Bacteria cause sores, yellow scabs, pimples or draining pus. They look like impetigo, a local skin bacterial infection. Can also become a painful red lump (boil)
- **Cellulitis (Serious).** The bacterial infection spreads into the skin. Gives redness that spreads out from the sore. The red area is painful to the touch.
- **Staph Scalded Skin Syndrome (Serious)**. SSSS is caused by a Staph bacteria. The main finding is widespread large blisters. The skin is bright red. The baby acts very sick.

Other Skin Rashes in Newborn Babies

Acne – Small red bumps on the face (onset 2-4 weeks).
Drooling or Spit-Up Rash – Rash around the mouth and on the chin (onset anytime).
Erythema Toxicum – Red blotches with small white "pimple" in the center (onset 2-3 days).
Skin Injury from Birth Process – From forceps, scalp electrode or birth canal (present at birth).
Milia – Tiny white bumps on the nose and cheeks (present at birth).
Mongolian Spots – Bluish-green birthmark, often on buttock (present at birth).
Stork Bites (Pink Birthmarks) – On back of neck or bridge of nose (present at birth).
Strawberry Hemangiomas – Raised red birthmarks (onset 2-4 weeks).
Port-wine Stains – Dark red or purple flat birthmarks (present at birth).

Newborn Face Rashes: Most Common Ones

- Erythema Toxicum 50% (onset day 2 or 3)
- Milia 40% (present at birth)
- Baby Acne 30% (onset week 2 to 4)
- Drooling or Spit-up Rash (common and onset any time)
- Heat Rash (common and onset any time)

Heat Rash

- Many newborn rashes that have no clear cause are heat rashes.
- Heat rashes are a pink blotchy area with tiny bumps.
- They mainly occur on the face, neck and chest.
- During hot weather, most temporary newborn rashes are heat rashes.
- Cause: Blocked off sweat glands. The openings are so tiny in newborns, that any irritation can block them. Examples are getting any ointment on the skin, friction from clothing or being overheated. Being held against the mother's skin while nursing causes many face rashes.

Herpes Simplex: Serious Newborn Rash

- **Appearance**. Several water blisters or pimples grouped in a cluster. They look like the cold sores (fever blisters) that adults get on their lip. After several days, they crust over.
- **Location.** Just one part of the body, usually the scalp or face.
- **Redness.** The base can be pink. The pinkness does not extend beyond the cluster of vesicles.
- **Onset.** Within the first 2 weeks of life.
- **Importance.** Early treatment with anti-viral drugs can prevent serious complications. If you think your newborn's rash looks like herpes, call your child's doctor now.
- **Imitator.** Although herpes can be confused with erythema toxicum, they look very different.

Bathing Your Newborn

Your infant doesn’t need much bathing if you wash the diaper area thoroughly during diaper changes. Three times a week during her first year may be enough. Bathing her more frequently may dry out her skin, particularly if soaps are used or moisture is allowed to evaporate from the skin. Patting her dry and applying a fragrance-free, hypoallergenic moisturizing lotion immediately after bathing can help prevent dry skin or worsening the skin condition called eczema.

During her first week or two, until the stump of the umbilical cord falls off, your newborn should have only sponge baths. In a warm room, lay the baby anywhere that’s flat and comfortable for both of you—a changing table, bed, floor, or counter next to the sink will do. Pad hard surfaces

with a blanket or fluffy towel. If the baby is on a surface above the floor, use a safety strap or keep one hand on her at all times to make sure she doesn't fall.

Have a basin of water, a damp, double-rinsed washcloth (so there is no soap residue in it), and a supply of mild baby soap within reach before you begin. Keep your baby wrapped in a towel, and expose only the parts of her body you are actively washing. Use the dampened cloth first without soap to wash her face, so you don't get soap into her eyes or mouth. Then dip it in the basin of soapy water before washing the remainder of her body and, finally, the diaper area. Pay special attention to creases under the arms, behind the ears, around the neck, and, especially with a girl, in the genital area.

Once the umbilical area is healed, you can try placing your baby directly in the water. Her first baths should be as gentle and brief as possible. She probably will protest a little; if she seems miserable, go back to sponge baths for a week or two, then try the bath again. She will make it clear when she's ready.

Most parents find it easiest to bathe a newborn in a bathinette, sink, or plastic tub lined with a clean towel. Fill the basin with 2 inches (5.08 cm) of water that feels warm—not hot—to the inside of your wrist or elbow. If you're filling the basin from the tap, turn the cold water on first (and off last) to avoid scalding yourself or your child. The hottest temperature at the faucet should be no more than 120 degrees Fahrenheit to avoid burns. In many cases you can adjust your water heater.

Preparedness

Make sure that supplies are at hand and the room is warm before undressing the baby. You'll need the same supplies that you used for sponge bathing, but also a cup for rinsing with clear water. When your child has hair, you'll need baby shampoo, too.

If you've forgotten something or need to answer the phone or door during the bath, you must take the baby with you, so keep a dry towel within reach. Never leave a baby alone in the bath, even for an instant.

If your baby enjoys her bath, give her some extra time to splash and explore the water. The more fun your child has in the bath, the less she'll be afraid of the water. As she gets older, the length of the bath will extend until most of it is taken up with play. Bathing should be a very relaxing and soothing experience, so don't rush unless she's unhappy.

Bath toys are not really needed for very young babies, as the stimulation of the water and washing is exciting enough. Once a baby is old enough for the bathtub, however, toys become invaluable. Containers, floating toys, even waterproof books make wonderful distractions as you cleanse your baby.

When your infant comes out of the bath, baby towels with built-in hoods are the most effective way to keep her head warm when she's wet. Bathing a baby of any age is wet work, so you may want to wear a terry-cloth apron or hang a towel over your shoulder to keep you dry.

The bath is a relaxing way to prepare her for sleep and should be given at a time that's convenient for you.

Bathing Your Baby
Once you've undressed your baby, place her in the water immediately so she doesn't get chilled. Use one of your hands to support her head and the other to guide her in, feet first. Speak to her encouragingly, and gently lower the rest of her body until she's in the tub. Most of her body and face should be well above the water level for safety, so you'll need to pour warm water over her body frequently to keep her warm.

Use a soft cloth to wash her face and hair, shampooing once or twice a week. Massage her entire scalp gently, including the area over her fontanelles (soft spots). When you rinse the soap or shampoo from her head, cup your hand across her forehead so the suds run toward the sides, not into her eyes. Should you get some soap in her eyes, and she cries out in protest, simply take the wet washcloth and liberally wipe her eyes with plain, lukewarm water until any remains of the soap are gone, and she will open her eyes again. Wash the rest of her body from the top down.

Settling In: The First Few Weeks of Breastfeeding
The first weeks of breastfeeding are a fascinating time of transition for you as well as your baby. During this time you will learn what it feels like to breastfeed, how to recognize your baby's hunger signals, and how to know when your let-down, or milk ejection reflex, has occurred. You will learn whether your baby is a frequent snacker or prefers less frequent but longer meals, whether nursing tends to put her to sleep or to stimulate her, and whether she enjoys pausing occasionally to exchange looks with you or focuses entirely upon nursing until she's had her fill. She will not always breastfeed in the same way, of course—just as you will not always be in the same mood each time you nurse. But you will begin to recognize and respond to breastfeeding cues. As you do so, the two of you will gradually grow more comfortable together, respond to each other's signals more effectively, and develop a unique breastfeeding rhythm.

Ideally, by the time you arrive home your baby will already have learned to latch on to the breast properly. Your newborn may even prefer one breast at this point, tending to nurse longer on one than on the other. It is a good idea to let her nurse as long as she wants. Keep in mind that once your mature milk comes in, its content changes during the course of a single breastfeeding from the somewhat watery foremilk to the creamier, fat-rich hind milk, which, like any good dessert, leaves your baby feeling content and sleepy. By allowing your baby to nurse until she's satisfied

(once she's latched on properly), you can ensure that she will receive all the benefits of breast milk.

Even if she clearly prefers one breast over the other, however, it's important to alternate the breast you offer first with each breastfeeding session. This ensures that a full milk supply is stimulated for both breasts and that as much milk as possible has been removed from each. At first, to remember which breast to start with, consider moving a safety pin from one side of your nursing bra to the other after each feeding. Later on you will know which breast feels fuller and start the next feeding there.

A Breastfeeding Checklist: Are You Nursing Correctly?
Signs of Correct Nursing

- Your baby's mouth is open wide with lips turned out.
- His chin and nose are resting against the breast.
- He has taken as much of the areola as possible into his mouth.
- He is suckling rhythmically and deeply, in short bursts separated by pauses.
- You can hear him swallowing regularly.
- Your nipple is comfortable after the first few suckles.

Signs of Incorrect Nursing

- Your baby's head is not in line with his body.
- He is sucking on the nipple only, instead of suckling on the areola with the nipple far back in his mouth.
- He is sucking in a light, quick, fluttery manner rather than taking deep, regular sucks.
- His cheeks are puckered inward or you hear clicking noises.
- You don't hear him swallow regularly after your milk production has increased.
- You experience pain throughout the feed or have signs of nipple damage (such as cracking or bleeding).

Positions For Breastfeeding
Once you and your baby have become pros at breastfeeding, you'll be able to nurse while talking on the phone, reading a book, supervising your other children, or walking around. For now, though it's best to start with as few distractions as possible.

Most new mothers first try breastfeeding sitting up in a hospital bed, with the baby supported by a pillow in their lap and cradled in their arms. If you choose this position, elevate the head of the bed as much as possible and place pillows behind you until your back is comfortable. Place your baby on a pillow on your lap (this is an especially good idea if you've given birth by cesarean section, or C-section) so his head is level with your breast. You might put pillows at your sides to rest your arms on so they won't tire in mid-feeding.

At home, you may find an armchair helpful. If you breastfeed while sitting in a chair, be sure it offers sturdy back and arm support and is not too low or high. A pillow or two tucked behind your back can make nursing in a chair more comfortable, as can a low footstool to support your legs. It is always important to make sure that you are comfortable before beginning the feeding.

Whether you are sitting up in bed or have settled into an armchair, keep your back straight but relaxed as you offer your baby the breast. Your baby may find it more difficult to latch on properly if you are leaning forward or back, since this changes the angle at which he receives the breast; your back may soon feel the strain of this as well. If your breasts are large, you might want to place a rolled-up towel or receiving blanket beneath your breast to keep your baby's mouth at a straight-on angle with the nipple, in addition to supporting the breast with your hand.

Once you are comfortably positioned, you can hold your baby in a number of ways. As you practice breastfeeding before leaving the hospital, try several positions (for both your baby and yourself) and ask your nurse or lactation specialist to check your technique. Using more than one position can help prevent nipple soreness and clogging of milk ducts, since different positions drain different areas of the breast more effectively. Some positions also work better than others in certain circumstances.

All of the positions described are for guidance only. There is not an absolute right or wrong way to hold your baby for breastfeeding. Every mother and baby find the positions that work well for them. If you are a first-time breastfeeding mother, however, you may find the following guidance helpful for getting started.

The Cradle Hold

The traditional position is called the *cradle hold or Madonna hold*. For this position, support your baby on the arm that's on the same side as the breast you intend to use. Holding your upper arm close to your body, rest your baby's head in the crook of your elbow, support his back with your forearm, and cup his bottom or upper thigh with your hand. His arm may be positioned around your body or tucked slightly under his body to keep it out of the way. Once he's properly supported, rotate your forearm so his entire body turns toward you. His pelvis should be up against your abdomen, his chest against your chest, and his mouth lined up with your nipple. You can now bring your baby's mouth to the nipple (rather than the nipple to his mouth) without making him turn his head to the side. It is important for your baby's head to be aligned with the rest of his body instead of turned off to the side.

The Cross-Cradle Hold

A variation on the cradle hold, the *cross-cradle* or *crossover hold* involves the same positioning except you support your baby on the arm opposite the breast being used. In this position, your hand supports your baby's neck and upper back, rather than his bottom, and his bottom rests either in the crook of your arm or on the pillow on your lap. Again, rotate your baby's body so it

faces you and his mouth is lined up with your nipple. This is a good position for a baby who has difficulty latching on, because you can more easily guide his head into a better position by holding the back of his neck between your thumb and fingers.

The Clutch Hold

Many breastfeeding women find that the *clutch hold*, also known as the *football hold*, is an easier position to maintain, particularly for those who have given birth by cesarean delivery, because it keeps the baby's weight off the abdominal incision. The clutch hold may also be useful for mothers of twins since one baby can nurse on each side, for women with large breasts or flat nipples since the mother can see both her nipple and her baby's mouth and can easily control the baby's head, and also for premature babies. In a clutch hold, your baby is held similarly to how you would hold a handbag clutched under your arm or a football clutched close to your body. To feed your baby in this position, place him beside you—on the side of the breast you will use—with his head near your breast. Tuck his body up against your side, under your arm. Your forearm should support his upper back, and your hand and fingers should support his shoulders, neck, and head. His legs will stretch out straight behind you or, if you are in a chair, you can rest his bottom against the back of the chair and angle his legs straight up. Finally, placing a pillow under your elbow for support, keep your baby's head level with your breast.

Reclining or Laying Down

You may find that feeding your baby in a *reclining* position, rather than sitting, allows for some welcome relaxation. Nursing while lying down helps particularly if you have had a cesarean delivery or otherwise feel tired or unwell in the days following childbirth. To do this, lie on your side with one or more pillows behind your back and under your head for support. (A pillow placed between your knees may make you more comfortable.) Keep your back and hips in as straight a line as possible. Hold your baby closely on his side so he faces you with his mouth with your arm around him. Support your breast with your other hand while guiding your baby closer with the arm supporting him.

An advantage of this position is you don't have to get up to reposition your baby on your other breast. Simply place a pillow under him to elevate him until he's parallel with your upper breast and lean over farther to bring the upper breast to him. Or, if you prefer, hug him to your chest, roll over to your other side, and reposition him. You can support your baby by placing a pillow or rolled-up blanket behind his back, thus giving your lower arm a rest.

Gastrocolic Reflex

If you really want to earn your cape, you'll remember the gastrocolic reflex. This is the medical term for the way the body makes room for incoming food by eliminating waste. In other words, it's not your imagination that your baby poops every time she nurses. Step in to handle this issue regularly and you can guarantee mom will be bragging about you to anyone who will listen. Seriously, this is the stuff women talk about—just run with it.

Listening
Listening, of course, is an especially important way you can help. Nursing may be natural, but it can also be quite frustrating and uncomfortable, especially at first. Mom's nipples may crack and bleed; her breasts can become uncomfortably engorged or even infected. You can help here, too, bringing her ointment or preparing warm compresses. But at times it's even more important that you just listen and offer sympathy. Your support may literally make the difference in helping mom overcome the challenges of nursing.

Dad's Role in Breastfeeding
Let's say you and mom have talked about it and decided to go with breastfeeding. There are tons of things you can do to help, beginning even before the baby is born. While breastfeeding is instinctive, there can be a lot to learn to make sure it goes as well as possible. Many hospitals, obstetricians, pediatricians, and freestanding lactation centers offer breastfeeding classes, which they encourage expectant fathers to attend. The more you know about nursing, the more helpful you can be when the time comes.

Successful nursing depends on a host of factors, many of which you can help with.

- **Positioning is key.** Mom may need a pillow or help propping up to get baby lined up just right. At that moment she's probably not in the best position to jump up and grab a pillow for support from across the room—you're on it!
- **Quench her thirst.** In addition to all the other things prolactin does, it often causes mom to feel intensely thirsty just as her milk is really starting to flow. Does she have a glass of cold water? You know what to do.
- **Be a hero.** Nursing goes best when mom is relaxed and feeling happy about her baby. Can you adjust the lighting? Put on some music? Rub her back? These are all opportunities to be a hero.

Facts For Fathers About Breastfeeding

- Breastfeeding babies tend to be healthier than formula-fed babies—and you won't have to deal with bottles, expensive cans of formula, or other equipment. You will save money that you would have spent to purchase formula.
- Breastfeeding has been shown to reduce the risk of breast, ovarian, and endometrial cancer in a mother's later life and may reduce the risk of osteoporosis.
- Breastfeeding women use the weight (fat stores) they accumulated during pregnancy to produce breast milk.
- Women who breastfeed for more than twelve months during their lifetime tend to have lower risk of high blood pressure, high cholesterol, heart disease, and diabetes.
- A mother's perception of her partner's attitude toward breastfeeding is one of the greatest factors influencing her decision to breastfeed.
- Exclusive breastfeeding, with no supplemental formula or solid feedings, delays the mother's ovulation and works as a natural form of birth control for the first six months

after childbirth, if the mother has not resumed her menstrual cycles and if her baby is continuing to breastfeed fully both day and through the night.

- A breastfeeding mother whose partner supports her by taking care of household responsibilities is likely to be more successful and keep breastfeeding longer, enjoy family life more, and have more energy left over for her adult relationships.
- Babies' brain development depends on frequent verbal, physical, and emotional interaction with a familiar, loving caregiver. Babies need to be sung to, rocked, and played with as much as they need time breastfeeding. The baby needs these things and they will not spoil her.
- Eye contact between parent and infant is important for infant development. Mother and baby frequently make eye contact during breastfeeding. The non-breastfeeding partner can maintain eye contact while changing her diaper, giving her a bath, and playing with her.
- Growing children benefit from experiencing the different but complementary parenting styles of two different adults.
- The American Academy of Pediatrics recommends breastfeeding as the sole source of nutrition for your baby for about 6 months. When you add solid foods to your baby's diet, a mother can continue breastfeeding until at least 12 months. A mother can continue to breastfeed after 12 months if she and your baby desire. Check with your child's doctor about vitamin D and iron supplements during the first year.

A Special Message to New Dads
While this time can be challenging for new fathers, it can also be uniquely rewarding.

Adjusting Priorities
Just as mothers occasionally need to readjust their priorities, fathers now have a golden opportunity to show more of their nurturing side by caring for Mom, the baby, and possibly other siblings. Although not all fathers have the option of paternity leave from work, those who do and take advantage of it may find it priceless. If Mom was the center of a sibling's universe and Dad was only an afterthought, Dad may suddenly be more "cool" once a newborn comes home.

By adjusting his priorities (at home and at work) and "rising to the occasion," Dad can strengthen an already strong bond with Mom as well as with the new child. By working as a team, parenting couples may be amazed at how well they can adapt to their new, stressful circumstances.

Teamwork
Of course, balancing the seemingly constant demands of the baby, the needs of other children, and the household chores is not always easy. Nights spent feeding, diapering, and walking the floor with a crying baby can quickly take their toll in fatigue for both parents. But by working as a team to relieve each other for naps, for exercise, and for "downtime," parenting couples might find that even though they share less "quality time" together, they may actually feel closer than

ever. Sometimes there may be conflict and jealous feelings. These are normal, and thankfully, temporary. Life soon settles into a fairly regular routine that will once again give you some time to yourselves and restore your sex life and social activities to normal.

Meanwhile, make an effort for just the two of you to spend some time together each day enjoying each other's company while the baby is sleeping or somebody else is caring for her. Remember, you're entitled to hold, hug, cuddle, and kiss each other as well as the baby.

Playing with Baby

A positive way for men to deal with these issues is to become as involved as possible in caring for and playing with the new baby. When you spend this extra time with your child, you'll get just as emotionally attached to her as her mother will.

This is not to say that moms and dads play with babies the same way. In general, fathers play to arouse and excite their babies, while mothers generally concentrate on more low-key stimulation such as gentle rocking, quiet interactive games, singing, and soothing activities. From the baby's viewpoint, both play styles are equally valuable and complement each other beautifully, which is another reason why it's so important to have both of you involved in the care of the baby.

Stay-At-Home Dads

SAHD stands for stay-at-home dad. While the 2010 US Census counted only the 154,000 fathers who cared for children while earning no income outside the home, a more realistic figure includes those dads who provide primary care for their children while their wives work, even if the dads work at other times. This number is closer to 1.5 million, and these dads care for a quarter of children younger than 5 years in the United States.

Finding Other SAHDs

While child care duties, cooking, cleaning, paying bills, and fixing the toilets leave little time for eating bonbons and watching soap operas, the real challenge is the sense of social isolation. Moms who work in the home can tap into a wide network of playgroups, neighborhood friends, and organized activities. But show up as the only guy at your local library's reading hour and you can actually see the moms scooting away from you in the imagination circle.

- The Internet or your local newspaper may help you find groups of dads to hang out with so you don't feel like a pariah on the park bench. Otherwise, start a group of your own!
- Check out www.daddyshome.org to see if there's already a group near you.

Identity & Self-Worth

SAHDs also may suffer a crisis of identity. Many of us have been raised to equate our earning power with self-esteem. Doing a job that is unpaid, even if you doing that job is what enables your family to stay afloat, can threaten your sense of self-worth. Until you've shopped for groceries and gone to the dry cleaners with your toddler on a Tuesday morning, you don't realize how few working-aged men there are out there at those times!

On the other hand, you can take pity on those men who don't get to watch their children's first steps or hear them learn their alphabets because they were working all day. What job really is more important than nurturing your child and creating a home? Here again, finding other men in your position will reinforce your sense that what you're doing is possibly the manliest job of all.

Colic Relief Tips for Parents

Does your infant have a regular fussy period each day when it seems you can do nothing to comfort her?

This is quite common, particularly between 6:00 p.m. and midnight—just when you, too, are feeling tired from the day's trials and tribulations. These periods of crankiness may feel like torture, especially if you have other demanding children or work to do, but fortunately they don't last long. The length of this fussing usually peaks at about three hours a day by six weeks and then declines to one or two hours a day by three to four months. As long as the baby calms within a few hours and is relatively peaceful the rest of the day, there's no reason for alarm.

If the crying does not stop, but intensifies and persists throughout the day or night, it may be caused by colic. About one-fifth of all babies develop colic, usually between the second and fourth weeks. They cry inconsolably, often screaming, extending or pulling up their legs, and passing gas. Their stomachs may be enlarged or distended with gas. The crying spells can occur around the clock, although they often become worse in the early evening.

What Causes Colic?

Unfortunately, there is no definite explanation for why this happens. Most often, colic means simply that the child is unusually sensitive to stimulation or cannot "self-console" or regulate his nervous system. (Also known as an immature nervous system.) As she matures, this inability to self-console—marked by constant crying—will improve. Generally this "colicky crying" will stop by three to four months, but it can last until six months of age. Sometimes, in breastfeeding babies, colic is a sign of sensitivity to a food in the mother's diet. The discomfort is caused only rarely by sensitivity to milk protein in formula. Colicky behavior also may signal a medical problem, such as a hernia or some type of illness.

Although You Simply May Have to Wait It Out, Several Things Might Be Worth Trying:

- **First, of course, consult your pediatrician** to make sure that the crying is not related to any serious medical condition that may require treatment. Then ask him which of the following would be most helpful.
- **If you're nursing,** you can try to eliminate milk products, caffeine, onions, cabbage, and any other potentially irritating foods from your own diet.
- **If you're feeding formula to your baby**, talk with your pediatrician about a protein hydrolysate formula. If food sensitivity is causing the discomfort, the colic should decrease within a few days of these changes.

- **Do not overfeed your baby**, which could make her uncomfortable. In general, try to wait at least two to two and a half hours from the start of one feeding to the start of the next one.
- **Walk your baby** in a baby carrier to soothe her. The motion and body contact will reassure her, even if her discomfort persists.
- **Rock her,** run the vacuum in the next room, or place her where she can hear the clothes dryer, a fan or a white-noise machine. Steady rhythmic motion and a calming sound may help her fall asleep. However, be sure to never place your child on top of the washer/dryer.
- **Introduce a pacifier.** While some breastfed babies will actively refuse it, it will provide instant relief for others.
- **Lay your baby tummy-down across your knees and gently rub her back.** The pressure against her belly may help comfort her.
- **Swaddle her** in a large, thin blanket so that she feels secure and warm.
- **When you're feeling tense and anxious, have a family member or a friend look after the baby—and get out of the house.** Even an hour or two away will help you maintain a positive attitude. No matter how impatient or angry you become, a baby should never be shaken. Shaking an infant hard can cause blindness, brain damage, or even death. Let your own doctor know if you are depressed or are having trouble dealing with your emotions, as she can recommend ways to help.

Fever and Your Baby
Your child's normal temperature will vary with his or her age, activity, and the time of day. Infants tend to have higher temperatures than older children, and everyone's temperature is highest between late afternoon and early evening and lowest between midnight and early morning.

Ordinarily, the following are considered normal, while higher readings indicate fever.
- Rectal reading of 100.4 degrees Fahrenheit (38 degrees Celsius) or less
- Oral reading of 99 degrees Fahrenheit (37.2 degrees Celsius) or less

Fever: A Sign or Symptom of Sickness
By itself, fever is *not* an illness. Rather, it is a sign or symptom of sickness. In fact, usually it is a positive sign that the body is fighting infection. Fever stimulates certain defenses, such as the white blood cells, which attack and destroy invading bacteria. The fever may actually be important in helping your child fight his or her infection. However, fever can make your child uncomfortable. It increases his or her need for fluids and makes his or her heart rate and breathing rate faster.

Fever most commonly accompanies respiratory illnesses such as:
- Croup
- Pneumonia
- Ear infections

- Influenza (flu)
- Severe colds
- Sore throats

It also may occur with infections of the bowel, blood, or urinary tract, inflammation of brain and spinal cord (meningitis), and with a wide variety of viral illnesses.

Febrile Convulsions
In children between six months and five years, fever can trigger seizures, called febrile convulsions. These convulsions tend to run in families, and usually happen during the first few hours of a febrile illness. Children may look "peculiar" for a few moments, then stiffen, twitch, and roll their eyes. They will be unresponsive for a short time, and their skin may appear to be a little darker than usual during the episode. The entire convulsion usually lasts less than one minute, and may be over in a few seconds, but it can seem like a lifetime to a frightened parent. Although uncommon, convulsions can last for up to fifteen minutes or longer. It is reassuring to know that febrile convulsions almost always are harmless—they do not cause brain damage, nervous system problems, paralysis, intellectual disabilities, or death—although they should be reported promptly to your pediatrician. If your child is having trouble breathing or the convulsion (also referred to as a seizure) does not stop within fifteen minutes, call 911.

Children younger than one year at the time of their first simple febrile convulsion have approximately a 50 percent chance of having another such seizure, while children over one year of age when they have their first seizure have about a 30 percent chance of having a second one. Nevertheless, febrile convulsions rarely happen more than once within a twenty-four-hour (one-day) period. Although many parents worry that a febrile convulsion will lead to epilepsy, keep in mind that epileptic seizures are not caused by a fever, and children with a history of fever related convulsions have only a slightly higher likelihood of developing epilepsy by age seven.

Don't Confuse Fever with Heatstroke
A rare but serious problem that is easily confused with fever is *heat-related illness*, or *heatstroke*. This is not caused by infection or internal conditions, but by surrounding heat. It can occur when a child is in a very hot place—for example, a hot beach in midsummer or an overheated closed car on a summer day. Leaving children unattended in closed cars is the cause of several deaths a year; never leave an infant or child unattended in a closed car, even for a few minutes.

Heatstroke also can occur if a baby is overdressed in hot, humid weather. Under these circumstances, the body temperature can rise to dangerous levels (above 105 degrees Fahrenheit (40.5 degrees Celsius), which must be reduced quickly by cool-water sponging, fanning, and removal to a cool place. After the child has been cooled, he or she should be taken immediately to a pediatrician or emergency room. **Heatstroke is an emergency condition.**

Use a Thermometer
Whenever you think your child has a fever, take his or her temperature with a thermometer. Feeling the skin (or using temperature sensitive tape) is not accurate, especially when the child is experiencing a chill.

Taking Your Child's Temperature
While you often can tell if your child is warmer than usual by feeling his forehead, only a thermometer can tell how high the temperature is. Even if your child feels warmer than usual, you do not necessarily need to check this temperature unless he has other signs of illness.

Always use a digital thermometer to check your child's temperature (*see "Types of digital thermometers" chart below for more information, including guidelines on what type of thermometer to use by age*). Mercury thermometers should not be used. The American Academy of Pediatrics (AAP) encourages parents to remove mercury thermometers from their homes to prevent accidental exposure and poisoning. **Note:** Temperature readings may be affected by how the temperature is measured and other factors. Your child's temperature *and* other signs of illness will help your doctor recommend treatment that is best for your child.

Types of Digital Thermometers
The following are 3 types of digital thermometers. While other methods for taking your child's temperature are available, such as pacifier thermometers or fever strips, they are not recommended at this time. Ask your child's doctor for advice.

Type*	How it works	Where to take the temperature	Age	Notes
Digital multiuse thermometer	Reads body temp when the sensor located on the tip of the thermometer touches that part of the body. Can be used rectally, orally, or axillary.	Rectal (in the bottom Oral (in the mouth) Axillary (under the arm)	Birth to 3 yrs 4 to 5 yrs and older Least reliable, technique, but useful for screening at any age	• 100.4 °F fever guideline is based on taking rectal reading. • Label thermometer "oral" or "rectal". Don't use the same thermometer in both places. • Taking an axillary temp is less reliable. However, this method may be used in schools and child care centers to check (screen) a child's temperature when a child has other signs of illness. This temp is used as a general guide.
Temporal artery	Reads the infrared heat waves released by the temporal artery, which runs across the forehead just below the skin.	On the side of the forehead	3 months and older Before 3 months, better as a screening device than armpit temperatures	• May be reliable in newborns and infants younger than 3 months according to new research.

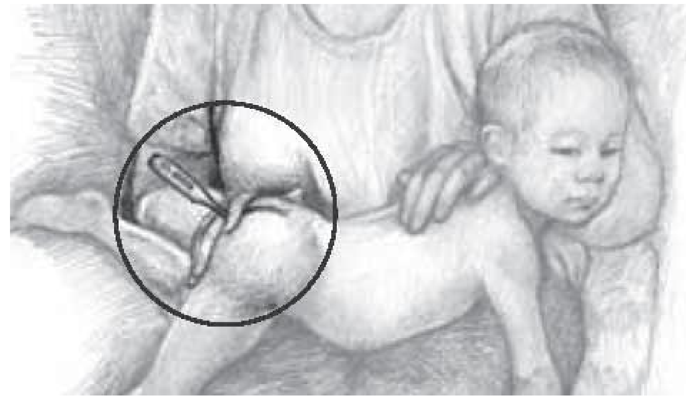
Tympanic	Reads the infrared heat waves released by the eardrum	In the ear	6 months and older	● Not reliable for babies younger than 6 months. ● When used in older children it needs to be placed correctly in your child's ear canal to be accurate. ● Too much earwax can cause the reading to be incorrect.

**Style and instructions may vary depending on the product*

How to Use a Digital Multiuse Thermometer
Rectal temperature

If your child is younger than 3 years, taking a **rectal temperature** gives the best reading. The following is how to take a rectal temperature:

- Clean the end of the thermometer with rubbing alcohol or soap and water. Rinse it with cool water. Do not rinse it with hot water.
- Put a small amount of lubricant, such as petroleum jelly, on the end.
- Place your child belly down across your lap or on a firm surface. Hold him by placing your palm against his lower back, just above his bottom. Or place your child face up and bend his legs to his chest. Rest your free hand against the back of the thighs.



- With the other hand, turn the thermometer on and insert it 1/2 inch to 1 inch into the anal opening. Do not insert it too far. Hold the thermometer in place loosely with 2 fingers, keeping your hand cupped around your child's bottom. Keep it there for about 1 minute, until you hear the "beep." Then remove and check the digital reading.

- Be sure to label the rectal thermometer so it's not accidentally used in the mouth.

Oral temperature
Once your child is 4 or 5 years of age, you can take his temperature by mouth. The following is how to take an **oral temperature**:

- Clean the thermometer with lukewarm soapy water or rubbing alcohol. Rinse with cool water.
- Turn the thermometer on and place the tip under your child's tongue toward the back of his mouth. Hold in place for about 1 minute, until you hear the "beep." Check the digital reading.
- For a correct reading, wait at least 15 minutes after your child has had a hot or cold drink before putting the thermometer in his mouth.

Digital thermometer drawings by Anthony Alex LeTourneau.

When to Call the Pediatrician for a Fever

When to call the doctor
The most important things you can do when your child has a fever are to improve your child's comfort by making sure they drink enough fluids to stay hydrated and monitor for signs and symptoms of a serious illness. It is a good sign if your child plays and interacts with you after receiving medicine for discomfort.

Call your child's doctor right away if your child has a fever and
- Looks very ill, is unusually drowsy, or is very fussy
- Has been in a very hot place, such as an overheated car
- Has other symptoms, such as a stiff neck, severe headache, severe sore throat, severe ear pain, an unexplained rash, or repeated vomiting or diarrhea

- Has immune system problems, such as sickle cell disease or cancer, or is taking steroids
- Has had a seizure
- Is younger than 3 months (12 weeks) and has a temperature of 100.4°F (38.0°C) or higher
- Fever rises above 104°F (40°C) repeatedly for a child of any age

Also call your child's doctor if

- Your child still "acts sick" once his fever is brought down.
- Your child seems to be getting worse.
- The fever persists for more than 24 hours in a child younger than 2 years.
- The fever persists for more than 3 days (72 hours) in a child 2 years of age or older.

Sleep

Babies do not have regular sleep cycles until about 6 months of age. While newborns sleep about 16 to 17 hours per day, they may only sleep 1 or 2 hours at a time. As babies get older, they need less sleep. However, different babies have different sleep needs. It is normal for a 6-month-old to wake up during the night but go back to sleep after a few minutes.

What's the best way to get my baby to go to sleep?

Babies do not have regular sleep cycles until about 6 months of age. While newborns sleep about 16 to 17 hours per day, they may only sleep 1 or 2 hours at a time. As babies get older, they need less sleep. However, different babies have different sleep needs. It is normal for a 6-month-old to wake up during the night but go back to sleep after a few minutes.

Here are some suggestions that may help your baby (and you) sleep better at night.

1. **Keep your baby calm and quiet when you feed or change her during the night**. Try not to stimulate or wake her too much.
2. **Make daytime playtime**. Talking and playing with your baby during the day will help lengthen her awake times. This will help her sleep for longer periods during the night.
3. **Put your baby to bed when drowsy but still awake**. This will help your baby learn to fall asleep on her own in her own bed. Holding or rocking her until she is completely asleep may make it hard for her to go back to sleep if she wakes up during the night.
4. **Wait a few minutes before responding to your child's fussing.** See if she can fall back to sleep on her own. If she continues to cry, check on her, but don't turn on the light, play with her, or pick her up. If she gets frantic or is unable to settle herself, consider what else might be bothering her. She may be hungry, wet or soiled, feverish, or otherwise not feeling well.

How to Keep Your Sleeping Baby Safe: AAP Policy Explained

By: Rachel Y. Moon, MD, FAAP

More than 3,500 babies in the U.S. die suddenly and unexpectedly every year while sleeping, often due to sudden infant death syndrome (SIDS) or accidental deaths from suffocation or strangulation. In an effort to reduce the risk of all sleep-related infant deaths, the American Academy of Pediatrics' (AAP) updated policy statement and technical report includes new

evidence that supports skin-to-skin care for newborn infants; addresses the use of bedside and in-bed sleepers; and adds to recommendations on how to create a safe sleep environment.

Note: All of these recommendations, unless mentioned otherwise, are for babies up to 1 year of age. Talk with your pediatrician if you have questions about any of the recommendations listed.

What You Can Do: Recommendations for Infant Sleep Safety

- **Until their first birthday, babies should sleep on their backs for all sleep times—for naps and at night**. We know babies who sleep on their backs are much less likely to die of SIDS than babies who sleep on their stomachs or sides. The problem with the side position is that the baby can roll more easily onto the stomach. Some parents worry that babies will choke when on their backs, but the baby's airway anatomy and the gag reflex will keep that from happening. Even babies with gastroesophageal reflux (GERD) should sleep on their backs.
  - Newborns should be placed skin-to-skin with their mother as soon after birth as possible, at least for the first hour. After that, or when the mother needs to sleep or cannot do skin-to-skin, babies should be placed on their backs in the bassinet. While preemies may need to be on their stomachs temporarily while in the NICU due to breathing problems, they should be placed on their backs after the problems resolve, so that they can get used to being on their backs and before going home.
  - Some babies will roll onto their stomachs. You should always place your baby to sleep on the back, but if your baby is comfortable rolling both ways (back to tummy, tummy to back), then you do not have to return your baby to the back. However, be sure that there are no blankets, pillows, stuffed toys, or bumper pads around your baby, so that your baby does not roll into any of those items, which could cause blockage of air flow.
  - If your baby falls asleep in a car seat, stroller, swing, infant carrier, or sling, you should move him or her to a firm sleep surface on his or her back as soon as possible.
- **Use a firm sleep surface.** A crib, bassinet, portable crib, or play yard that meets the safety standards of the Consumer Product Safety Commission (CPSC) is recommended along with a tight-fitting, firm mattress and fitted sheet designed for that particular product. Nothing else should be in the crib except for the baby. A firm surface is a hard surface; it should not indent when the baby is lying on it. Bedside sleepers that meet CPSC safety standards may be an option, but there are no published studies that have examined the safety of these products. In addition, some crib mattresses and sleep surfaces are advertised to reduce the risk of SIDS. There is no evidence that this is true, but parents can use these products if they meet CPSC safety standards.
- **Room share—keep baby's sleep area in the same room where you sleep for the first 6 months or, ideally, for the first year**. Place your baby's crib, bassinet, portable crib, or play yard in your bedroom, close to your bed. The AAP recommends room sharing because it can decrease the risk of SIDS by as much as 50% and is much safer than bed sharing. In addition, room sharing will make it easier for you to feed, comfort, and watch your baby.

- **Only bring your baby into your bed to feed or comfort**. Place your baby back in his or her own sleep space when you are ready to go to sleep. If there is any possibility that you might fall asleep, make sure there are no pillows, sheets, blankets, or any other items that could cover your baby's face, head, and neck, or overheat your baby. As soon as you wake up, be sure to move the baby to his or her own bed.
- **Never place your baby to sleep on a couch, sofa, or armchair**. This is an extremely dangerous place for your baby to sleep.
- **Bed-sharing is not recommended for any babies**. However, certain situations make bed-sharing even more dangerous. Therefore, you should not bed share with your baby if:
    - Your baby is younger than 4 months old.
    - Your baby was born prematurely or with low birth weight.
    - You or any other person in the bed is a smoker (even if you do not smoke in bed).
    - The mother of the baby smoked during pregnancy.
    - You have taken any medicines or drugs that might make it harder for you to wake up.
    - You drank any alcohol.
    - You are not the baby's parent.
    - The surface is soft, such as a waterbed, old mattress, sofa, couch, or armchair.
    - There is soft bedding like pillows or blankets on the bed.

- **Keep soft objects, loose bedding, or any objects that could increase the risk of entrapment, suffocation, or strangulation out of the baby's sleep area**. These include pillows, quilts, comforters, sheepskins, blankets, toys, bumper pads or similar products that attach to crib slats or sides. If you are worried about your baby getting cold, you can use infant sleep clothing, such as a wearable blanket. In general, your baby should be dressed with only one layer more than you are wearing.
- **It is fine to swaddle your baby**. However, make sure that the baby is always on his or her back when swaddled. The swaddle should not be too tight or make it hard for the baby to breathe or move his or her hips. When your baby looks like he or she is trying to roll over, you should stop swaddling.
- **Try giving a pacifier at nap time and bedtime**. This helps reduce the risk of SIDS, even if it falls out after the baby is asleep. If you are breastfeeding, wait until breastfeeding is going well before offering a pacifier. This usually takes 2-3 weeks. If you are not breastfeeding your baby, you can start the pacifier whenever you like. It's OK if your baby doesn't want a pacifier. You can try offering again later, but some babies simply don't like them. If the pacifier falls out after your baby falls asleep, you don't have to put it back in.

What Moms Can Do: Recommendations for Prenatal & Postnatal

- **Do not smoke during pregnancy or after your baby is born**. Keep your baby away from smokers and places where people smoke. If you are a smoker or you smoked during pregnancy, it is very important that you do not bed share with your baby. Also, keep your car and home smoke-free. Don't smoke anywhere near your baby, even if you are outside.

- **Do not use alcohol or illicit drugs during pregnancy or after the baby is born**. It is very important not to bed share with your baby if you have been drinking alcohol or taken any medicines or illicit drugs that can make it harder for you to wake up.
- **Breastfed babies have a lower risk of SIDS**. Breastfeed or feed your baby expressed breast milk. The AAP recommends breastfeeding as the sole source of nutrition for your baby for about 6 months. Even after you add solid foods to your baby's diet, continue breastfeeding for at least 12 months, or longer if you and your baby desire.
- **Schedule and go to all well-child visits**. Your baby will receive important immunizations at these doctor visits. Recent evidence suggests that immunizations may have a protective effect against SIDS.
- **Make sure your baby has tummy time every day**. Awake tummy time should be supervised by an awake adult. This helps with baby's motor development and prevents flat head syndrome.

Use Caution When Buying Products

- **Use caution when a product claims to reduce the risk of SIDS.** Wedges, positioners, special mattresses and specialized sleep surfaces have not been shown to reduce the risk of SIDS, according to the AAP.
- **Do not rely on home heart or breathing monitors to reduce the risk of SIDS**. If you have questions about using these monitors for other health conditions, talk with your pediatrician.
- **There isn't enough research on bedside or in-bed sleepers**. The AAP can't recommend for or against these products because there have been no studies that have looked at their effect on SIDS or if they increase the risk of injury and death from suffocation.

Putting Back-Sleeping Concerns to Rest

We're willing to bet that this isn't the first time you've been introduced to the benefits of raising a back-sleeping baby. Most new parents today are well informed when it comes to SIDS and why back sleeping is so strongly recommended. We'd be missing the boat, however, if we didn't acknowledge the fact that you may find yourself with some practical concerns when faced with putting principle into practice. For the most part, the following concerns cause parents to worry unnecessarily:

- **Spitting up and vomiting.** The most common concern we hear is the understandable but unfounded fear that babies will spit up and choke while on their backs. Fortunately, several reassuring studies as well as the test of time have demonstrated that healthy babies put to sleep on their backs are not only able to turn their heads and/or protect their airways if and when they spit up, but are no more likely to have breathing or digestive-related problems than their belly-sleeping counterparts of years past.
- **Flat heads.** It is true that the shape of your newborn's head is not yet set in stone, and that there has been an increase in the number of babies "walking" around with flat heads since back sleeping came into vogue. The fact of the matter is that it's really not that much of a problem for most back-sleeping babies. In large part, that's because you have a

good deal of control over the situation. All you need to do is alternate the direction your baby faces each time she lies on her back— both while she is asleep and also when awake. By offering your newborn plenty of tummy time and time spent in positions other than flat on her back while she is awake, you can also help decrease the likelihood of a flat or misshapen head.

- **Delayed milestones.** Some of you will undoubtedly hear or read that back sleeping has been associated with delayed motor development. In addressing the question of delayed milestones—or more specifically, a delay in the time when back-sleeping babies first begin to roll over—rest assured that this all seems to even out in the end. Even if your baby doesn't take to rolling quite as early as her belly-sleeping counterparts of generations past and present, to our knowledge no college application has ever asked applicants how early they mastered the ability to roll over (or, for future reference, sit, crawl, walk, or toilet train). When it comes to strengthening the muscles your baby needs to roll and, at the same time, decreasing your baby's chances of ending up with a flat head, just be aware that both can be easily accomplished by allowing your baby plenty of time on her belly when she's awake.

Reduce the Risk of SIDS & Suffocation

About 3,500 babies die each year in the United States during sleep because of unsafe sleep environments. Some of these deaths are caused by entrapment, suffocation, or strangulation. Some infants die of sudden infant death syndrome (SIDS). However, there are ways for parents to keep their sleeping baby safe.

Read on for more information from the American Academy of Pediatrics (AAP) on how parents can create a safe sleep environment for their babies. This information should also be shared with anyone who cares for babies, including grandparents, family, friends, babysitters, and child care center staff.

Note: These recommendations are for healthy babies up to 1 year of age. A very small number of babies with certain medical conditions may need to be placed to sleep on their stomach. Your baby's doctor can tell you what is best for your baby.

What You Can Do:

- **Place your baby to sleep on his back for every sleep.**
    - Babies up to 1 year of age should always be placed on their back to sleep during naps and at night. However, if your baby has rolled from his back to his side or stomach on his own, he can be left in that position if he is already able to roll from tummy to back and back to tummy.
    - If your baby falls asleep in a car seat, stroller, swing, infant carrier, or infant sling, he should be moved to a firm sleep surface as soon as possible.
    - Swaddling (wrapping a light blanket snuggly around a baby) may help calm a crying baby. If you swaddle your baby, be sure to place him on his back to sleep. Stop swaddling your baby when he starts to roll.
- **Place your baby to sleep on a firm sleep surface.**

    - The crib, bassinet, portable crib, or play yard should meet current safety standards. Check to make sure the product has not been recalled. Do not use a crib that is broken or missing parts or that has drop-side rails. For more information about crib safety standards, visit the Consumer Product Safety Commission Web site.
    - Cover the mattress with a tight-fitting sheet.
    - Do not put blankets or pillows between the mattress and fitted sheet.
    - Never put your baby to sleep on a water bed, a cushion, or a sheepskin.
- **Keep soft objects, loose bedding, or any objects that could increase the risk of entrapment, suffocation, or strangulation out of the crib.**
    - Pillows, quilts, comforters, sheepskins, bumper pads, and stuffed toys can cause your baby to suffocate. Note: Research has not shown us when it's 100% safe to have these objects in the crib; however, most experts agree that these objects pose little risk to healthy babies after 12 months of age.
- **Place your baby to sleep in the same room where you sleep but not the same bed.**
    - Do this for at least 6 months, but preferably up to 1 year of age. Room-sharing decreases the risk of SIDS by as much as 50%.
    - Keep the crib or bassinet within an arm's reach of your bed. You can easily watch or breastfeed your baby by having your baby nearby.
    - The AAP cannot make a recommendation for or against the use of bedside sleepers or in-bed sleepers until more studies are done.
    - Babies who sleep in the same bed as their parents are at risk of SIDS, suffocation, or strangulation. Parents can roll onto babies during sleep, or babies can get tangled in the sheets or blankets.
- **Breastfeed as much and for as long as you can. This helps reduce the risk of SIDS.**
    - The AAP recommends breastfeeding as the sole source of nutrition for your baby for about 6 months. When you add solid foods to your baby's diet, continue breastfeeding until at least 12 months. You can continue to breastfeed after 12 months if you and your baby desire.
- **Schedule and go to all well-child visits. Your baby will receive important immunizations.**
    - Recent evidence suggests that immunizations may have a protective effect against SIDS.
- **Keep your baby away from smokers and places where people smoke. This helps reduce the risk of SIDS.**
    - If you smoke, try to quit. However, until you can quit, keep your car and home smoke-free. Don't smoke inside your home or car, and don't smoke anywhere near your baby, even if you are outside.
- **Do not let your baby get too hot. This helps reduce the risk of SIDS.**
    - Keep the room where your baby sleeps at a comfortable temperature.
    - In general, dress your baby in no more than one extra layer than you would wear. Your baby may be too hot if she is sweating or if her chest feels hot.
    - If you are worried that your baby is cold, use a wearable blanket, such as a sleeping sack, or warm sleeper that is the right size for your baby. These are made to cover the body and not the head.

- **Offer a pacifier at nap time and bedtime. This helps reduce the risk of SIDS.**
  - If you are breastfeeding, wait until breastfeeding is going well before offering a pacifier. This usually takes 3 to 4 weeks. If you are not breastfeeding, you can start a pacifier as soon as you like.
  - It's OK if your baby doesn't want to use a pacifier. You can try offering a pacifier again, but some babies don't like to use pacifiers.
  - If the pacifier falls out after your baby falls asleep, you don't have to put it back in.
  - Do not use pacifiers that attach to infant clothing.
  - Do not use pacifiers that are attached to objects, such as stuffed toys and other items that may be a suffocation or choking risk.
- **Do not use home cardiorespiratory monitors to help reduce the risk of SIDS.**
  - Home cardiorespiratory monitors can be helpful for babies with breathing or heart problems, but they have not been found to reduce the risk of SIDS.
- **Use caution when buying products that claim to reduce the risk of SIDS.**
  - Wedges, positioners, special mattresses and specialized sleep surfaces have not been shown to reduce the risk of SIDS, according to the AAP.

What Expectant Moms Can Do:

- Schedule and go to all prenatal doctor visits.
- Do not smoke, drink alcohol, or use drugs while pregnant or after the birth of your newborn. Stay away from smokers and places where people smoke.
- Hold your newborn skin to skin while breastfeeding. If you can breastfeed, do this as soon as you can after birth. Skin-to-skin contact is also beneficial for bottle-fed newborns.

What Sleepy Parents Need to Know:

- It is safer to feed your baby on your bed than on a sofa or cushioned chair. Make sure to remove pillows, blankets, or other soft bedding, in case you fall asleep while feeding. If you do fall asleep, move your baby back into her own bed as soon as you awake.
- Be careful not to fall asleep on a sofa or cushioned chair while holding your baby.

Remember Tummy Time:

Give your baby plenty of "tummy time" when she is awake. This will help strengthen neck muscles and help prevent flat spots on the head. Always stay with your baby during tummy time, and make sure she is awake.

Suitable Sleeping Sites

At first, we figured we ought to allot a good bit of time to addressing the various sleep-site options available to you—starting predictably with the crib and then running through everything from bassinets, cradles, co-sleepers, and playpens to car seats and dresser drawers. Then it occurred to us that most parents we talk to seem to handle this part of new parenthood pretty well on their own, and either don’t care too much or already have their hearts set on one or the other (or several) of the options. Given that there are plenty of informative baby product books

like *Baby Bargains* and Consumer Reports' *Best Baby Products* around, we decided not to take up too much of your time on the subject. Instead, we are going to lay out for you what we consider to be the practical considerations and safety tips most useful in deciding where to lay your baby down to rest.

Crib Safety Considerations

Whether you decide to set up a crib for your baby as soon as your pregnancy test turns positive or months after your newborn's much-anticipated arrival, there are a few general safety principles that you'll want to follow to ensure your baby's safety. Some may not seem particularly relevant during your baby's first few months, but given that cribs tend to be big-ticket items and the one you invest in is going to be put to the test for years to come as your baby learns to roll, sit, stand, and climb in it, it's well worth considering present and future safety concerns. You can check for crib recalls at www.cpsc.gov/info/cribs/index.html.

- **Crib slats.** The slats should be no more than 2-3/8 inches apart. All new cribs must meet this standard, but older cribs may not.
- **Posts and cutouts.** Steer clear of bedposts taller than 1/16th of an inch and/or cutouts in the headboard (or any other parts of the crib) where a baby's or toddler's body parts could get stuck.
- **Crib toys.** They may seem harmless, entertaining, cute, and cuddly, but it's considered wise to keep all stuffed animals (and most toys) out of your newborn's crib because they can pose a small but nevertheless real safety risk. The exceptions are the types of toys that strap securely to the side of the crib. Some babies like mirrors or toys with parts they can play with (such as spinners, rattles, and music), but your newborn probably won't be terribly interested in them for at least a few weeks.
- **Mobiles.** Mobiles are special hanging toys designed to entertain your baby and can be attached to the crib, ceiling, or wall. Some are even adorned with lights or play music. They are fun but definitely optional. If you do choose to use mobiles, make sure they do not hang low enough to entangle your baby, especially once she begins to roll. In fact, once your baby is able to sit up, it will definitely be time for her mobile to come down.
- **Crib placement.** Unless you don't mind a bit of redecorating and rearranging when your baby starts to get around, we suggest you place your crib well away from any windows and no less than an arm's reach away from any nearby dressers or table-tops. Knowing that it won't be long before anything and everything within reach will be fair game, we also recommend limiting your over-the-crib wall decorations to painted walls and wallpaper. Picture frames and mirrors over cribs are often an accident waiting to happen. Be forewarned that even paper borders placed within reach of the crib, while safe, don't often stand up well to prying fingers.
- **Firm-fitting mattress/fitted sheet.** While they seem to be mostly standardized, cribs and mattresses can and do come in more than one size, so be sure to double-check measurements and read labels to make sure you end up with a mattress that fits snugly into your chosen crib. Any extra space between the mattress and crib frame has the

potential to trap a baby's arm, leg, or head. Also make sure your fitted sheets are tight enough that they don't slip off easily, thus posing a serious safety hazard.

- **Tooth-resistant rails.** Some railings are covered by a special plastic to prevent teething babies from gnawing on the paint or wood.
- **Adjustable mattress height.** Many cribs have adjustable heights so you can lower the mattress as your baby gets taller, making it more difficult for him to climb out. You will likely want to keep it at the highest level while your newborn is relatively immobile and you are coming and going frequently because it will allow you to save a good deal of strain on your back. Remember that by the time your baby is able to sit or stand up, you'll want to lower the level of the crib mattress accordingly.

Raising Concerns About Drop-Side Cribs

In recent years, crib railings have almost always been adjustable—meaning you can raise and lower one or both side railings. While this feature has long been appealing to parents as a convenience factor, it has now become one of significant concern. That's because numerous injuries from crib side-rails resulted in the largest crib recall in history (2.1 million cribs!) in 2009. As a result, the organization that sets voluntary industry safety standards required that going forward, all full-sized cribs be manufactured with 4 immovable sides. In other words, drop-side cribs may soon become a thing of the past. The take-home message for all parents: Always be sure to check out the latest safety information on the Consumer Product Safety Commission Web site before dropping your guard.

Baby Bedding, Bumpers, and Blankets

If you come to find that the excitement you feel about having a new baby is wrapped up in the buying of a fancy baby bedding set complete with bumper and quilted blanket, then don't let us stop you. After all, we couldn't resist the parental urge to splurge either—at least not the first time around. For those of you who are interested in taking a more minimalist approach, now is the time for us to point out that as cute as it may be to walk into the nursery and see the lamp match the wallpaper border match the blanket match the diaper holder…you get the picture, you really don't need any of it.

For safety's sake, keep soft objects or loose bedding out of the crib. This includes pillows, blankets, and bumper pads. Bumper pads should not be used in cribs. There is no evidence that bumper pads prevent injuries, and there is a potential risk of suffocation, strangulation or entrapment. The receiving blanket(s) and/or pajamas you use to wrap your baby in should be enough for warmth.

Bassinets and Cradles

For the first few weeks of a baby's life, some parents prefer to use a bassinet or cradle because it's portable and allows the baby to sleep in their bedroom. But keep in mind that babies grow fast and a cradle that's sturdy enough for a 1-month-old may be outgrown by the next month.

Make sure the bottom of the cradle or bassinet is well supported to prevent its collapse. The cradle or bassinet should also have a wide base so it won't tip over even if someone bumps it; if

it has folding legs, make certain that they're locked straight whenever it is being used. In general, your baby should move to a crib around the end of the first month of life or by the time he weighs 10 pounds.

Changing Diapers

Location, Location, Location

Wherever you choose to change your baby's diaper—whether it's on your brand new changing table or next to you on your bed—you'll want to prepare the area so that everything you need is accessible. At a minimum, this means a diaper and some wipes. While changing tables are clearly the norm when it comes to location, and some people, one of us included, even opt to have more than one around the house, you should be aware (if you aren't already) that they aren't inherently necessary. If you decide that you don't want your diaper changing to be limited geographically by where your changing table happens to be, then also consider keeping diapers accessible in convenient locations around the house (and in the car once you start to venture out). That way, you can limit how far you have to go to take care of business. Some people opt to use a simple diaper changing pad in lieu of the table, and the floor, bed, couch, or even the back seat of your car can easily serve the same purpose once you are comfortable with the routine. That said, some particularly messy episodes might require not only a new diaper, but also an extra pair of hands, a new outfit, and even a trip to the tub. On such occasions, you'll be much better off if you've chosen your "changing station" in close proximity to your supplies.

The Technique

Before starting to change your baby's diaper, keep in mind that some babies have a tendency to pee as soon as they are exposed to open air. By keeping them relatively covered as much as you can during the course of a diaper change, you can help keep yourself, your changing surface, and your baby's clothes from getting unnecessarily wet.

If your baby is cooperative, which most babies are at least until they learn how to roll (somewhere around 4 months), you can first lift her legs with one hand and place a clean diaper under her bottom with the other. Make sure you have the picture side of the new diaper in front and the side with the tabs underneath. *Then* unfasten the old diaper and wipe your baby's bottom with the front (inner side) of it as you remove it. While you clearly don't have to wipe with the old diaper before taking it off, doing so can often remove a significant amount of poop before you reach for your first baby wipe. If the old diaper isn't overwhelmingly messy, leaving it folded over on itself but still under your baby's bottom can help prevent her still-dirty bottom from getting the new diaper soiled before you've had the chance to clean her up, and also serve to absorb any new pee that may present itself during the uncovered stage of the diaper change.

Next, wipe your baby's bottom and surrounding dirty areas with a baby wipe, moist tissue, or washcloth. Then remove the old diaper along with the wipes from underneath your baby (if you haven't already) and find a "safe" place to set them so that you don't end up with your baby's foot in poop, or find yourself with a new mess to clean up after accidentally knocking the diaper and its contents to the floor.

Securing the new diaper simply involves making sure that the front of the diaper is centered between the legs and pulled up to at least the same level in the back that it is in the front—usually around the level of the belly button. Check to see that the tabs are evenly secured in the front so that there aren't any gaps around the hips. Also, to help prevent leakage, make sure that the fringe around the legs isn't tucked into the diaper's elastic edges.

Disposable changing pads (available in most drugstores and sometimes referred to as bed liners) can be helpful in protecting your changing table, crib, bed, floor, or wherever else you may choose to set up shop. These are especially good when you're away from home because they can be used first as a changing pad and then to wrap the dirty diaper for a quick and easy disposal. If you're at home and don't mind a bit of extra laundry, a towel can easily serve the same purpose.

Pacifier Safety

Pacifiers will not harm your baby. In fact, there is some evidence that pacifiers may help reduce the risk of sudden infant death syndrome (SIDS).

Use the following tips when giving your baby a pacifier:

- Do not use the top and nipple from a baby bottle as a pacifier, even if you tape them together. If the baby sucks hard, the nipple may pop out of the ring and choke her.
- Purchase pacifiers that cannot possibly come apart. Those molded of one solid piece of plastic are particularly safe. If you are in doubt, ask your pediatrician for a recommendation.
- The shield between the nipple and the ring should be at least 1-1⁄2 inches (3.8 cm) across, so the infant cannot take the entire pacifier into her mouth. Also, the shield should be made of firm plastic with ventilation holes.
- Never tie a pacifier to your child's crib or around your child's neck or hand. This is very dangerous and could cause serious injury or even death.
- Pacifiers deteriorate over time. Inspect them periodically to see whether the rubber is discolored or torn. If so, replace them. In addition, follow the recommended age range on the pacifier, as older children can sometimes fit an entire newborn pacifier in their mouth and choke

Baby Walkers: A Dangerous Choice

Baby walkers send thousands of children to hospitals every year. Read about why they are not safe and what you can do.

Children in Baby Walkers Can:

- **Roll down the stairs**—which often causes broken bones and severe head injuries. This is how most children get hurt in baby walkers.
- **Get burned**—a child can reach higher in a walker. It is now easier for a child to pull a tablecloth off a table and spill hot coffee, grab pot handles off the stove, and reach radiators, fireplaces, or space heaters.
- **Drown**—a child can fall into a pool or bathtub while in a walker. *See Pool Dangers and Drowning Prevention—When It's Not Swimming Time for more information.*
- **Be poisoned**—reaching high objects is easier in a walker.

Most walker injuries happen while adults are watching. Parents or caregivers simply cannot respond quickly enough. A child in a walker can move more than 3 feet in 1 second! That is why walkers are never safe to use, even with an adult close by.

There are no benefits to baby walkers.

Many parents think walkers will help their children learn to walk. But they don't. In fact, walkers can actually delay when a child starts to walk.

What Parents Can Do:

- **Throw out your baby walkers!** Also, be sure that there are no walkers wherever your child is being cared for, such as child care centers or in someone else's home.
- **Try something just as enjoyable but safer, like**
  - **Stationary activity centers**—they look like walkers but have no wheels. They usually have seats that rotate, tip, and bounce.
  - **Play yards or playpens**—these are great safety zones for children as they learn to sit, crawl, or walk.
  - **High chairs**—older children often enjoy sitting up in a high chair and playing with toys on the tray.
  -

About Safety Standards:

New safety standards for baby walkers have been in place since 1997. They are now made wider so they cannot fit through most doors, or they have brakes to stop them at the edge of a step. However, these improvements will not prevent all injuries from walkers. They still have wheels, so children can still move fast and reach higher.

The American Academy of Pediatrics has called for a ban on the manufacture and sale of baby walkers with wheels.

Baby walkers are banned in Canada!
Under the Canada Consumer Product Safety Act (2004), Canadians are not allowed to manufacture, import, advertise or sell baby walkers. Canada is the first country to have such a law against them.

Remember:
One way you can keep your child safe from injury is to throw away your baby walker.

AAP Updates Recommendations on Car Seats

Children should ride rear-facing to age 2, use a booster until at least age 8
New advice from the American Academy of Pediatrics (AAP) will change the way many parents buckle up their children for a drive.

In a new policy published in the April 2011 issue of *Pediatrics* (published online March 21), the AAP advises parents to keep their toddlers in rear-facing car seats until age 2, or until they reach the maximum height and weight for their seat. It also advises that most children will need to ride in a belt-positioning booster seat until they have reached 4 feet 9 inches tall and are between 8 and 12 years of age.
The previous policy, from 2002, advised that it is safest for infants and toddlers to ride rear-facing up to the limits of the car seat, but it also cited age 12 months and 20 pounds as a minimum. As a result, many parents turned the seat to face the front of the car when their child celebrated his or her first birthday.
“Parents often look forward to transitioning from one stage to the next, but these transitions should generally be delayed until they’re necessary, when the child fully outgrows the limits for his or her current stage,” said Dennis Durbin, MD, FAAP, lead author of the policy statement and accompanying technical report.
“A rear-facing child safety seat does a better job of supporting the head, neck and spine of infants and toddlers in a crash, because it distributes the force of the collision over the entire body,” Dr. Durbin said. “For larger children, a forward-facing seat with a harness is safer than a booster, and a belt-positioning booster seat provides better protection than a seat belt alone until the seat belt fits correctly.”
While the rate of deaths in motor vehicle crashes in children under age 16 has decreased substantially – dropping 45 percent between 1997 and 2009 – it is still the leading cause of death for children ages 4 and older. Counting children and teens up to age 21, there are more than 5,000 deaths each year. Fatalities are just the tip of the iceberg; for every fatality, roughly 18 children are hospitalized and more than 400 are injured seriously enough to require medical treatment.

New research has found children are safer in rear-facing car seats. A 2007 study in the journal *Injury Prevention* showed that children under age 2 are 75 percent less likely to die or be severely injured in a crash if they are riding rear-facing.

“The ‘age 2’ recommendation is not a deadline, but rather a guideline to help parents decide when to make the transition,” Dr. Durbin said. “Smaller children will benefit from remaining

rear-facing longer, while other children may reach the maximum height or weight before 2 years of age."
Children should transition from a rear-facing seat to a forward-facing seat with a harness, until they reach the maximum weight or height for that seat. Then a booster will make sure the vehicle's lap-and-shoulder belt fit properly. The shoulder belt should lie across the middle of the chest and shoulder, not near the neck or face. The lap belt should fit low and snug on the hips and upper thighs, not across the belly. Most children will need a booster seat until they have reached 4 feet 9 inches tall and are between 8 and 12 years old.

Children should ride in the rear of a vehicle until they are 13 years old.
Although the Federal Aviation Administration permits children under age 2 to ride on an adult's lap on an airplane, they are best protected by riding in an age- and size-appropriate restraint. "Children should ride properly restrained on every trip in every type of transportation, on the road or in the air," Dr. Durbin said.

Car Seat Checkup
Using a car seat correctly makes a big difference. Even the right seat for your child's size must be used correctly to properly protect your child in a crash. **Here are car seat tips from the American Academy of Pediatrics.**

Does your car have air bags?

- Never place a rear-facing car seat in the front seat of a vehicle that has a front passenger airbag. If the airbag inflates, it will hit the back of the car seat, right where your baby's head rests, and could cause serious injury or death.
- The safest place for all children younger than 13 years to ride is in the back seat regardless of weight and height.
- If an older child must ride in the front seat, a child in a forward-facing car seat with a harness may be the best choice. Be sure you move the vehicle seat as far back from the dashboard (and airbag) as possible.

Is your child facing the right way for weight, height, and age?

- All infants and toddlers should ride in a rear-facing car seat as long as possible, until they reach the highest weight or height allowed by their car seat manufacturer.
- Any child who has outgrown the rear-facing weight or height limit for his car seat should use a forward-facing seat with a harness for as long as possible, up to the highest weight or height allowed by his car seat manufacturer.

Is the harness snug?

- Harness straps should fit snugly against your child's body. Check the car seat instructions to learn how to adjust the straps.
- Place the chest clip at armpit level to keep the harness straps secure on the shoulders.

Does the car seat fit correctly in your vehicle?

- Not all car seats fit properly in all vehicles.
- Read the section on car seats in the owner's manual for your car.

Can you use the LATCH system?

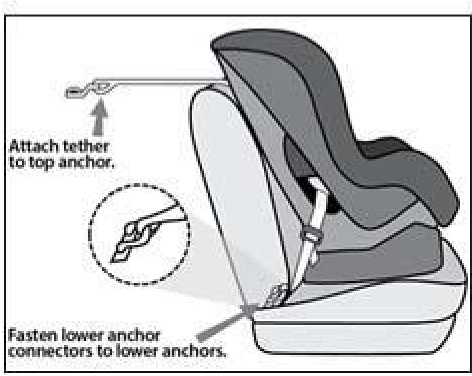


Figure 1. Car safety seat with LATCH.

- LATCH (lower anchors and tethers for children) is a car seat attachment system that can be used instead of the seat belt to install the seat. These systems are equally safe, but in some cases, it may be easier to install the car seat using LATCH.
- Vehicles with the LATCH system have anchors located in the back seat, where the seat cushions meet. All car seats have attachments that fasten to these anchors. Nearly all passenger vehicles made on or after September 1, 2002, and all car seats are equipped to use LATCH. All lower anchors are rated for a maximum weight of 65 pounds (total weight includes car seat and child). Check the car seat manufacturer's recommendations for the maximum weight a child can be to use lower anchors. New car seats have the maximum weight printed on their label.
- The top tether improves safety provided by the seat. Use the tether for all forward-facing seats. Check your vehicle owner's manual for the location of tether anchors. Always follow both the car seat and vehicle manufacturer instructions, including weight limits, for lower anchors and tethers. Remember, weight limits are different for different car seats and different vehicles.

Figure 2. Rear-facing–only car safety seat.

Is the seat belt or LATCH strap in the right place and pulled tight?

- Route the seat belt or LATCH strap through the correct path. Convertible seats have different belt paths for when they are used rear facing or forward facing (check your instructions to make sure).

- Pull the belt tight. Apply weight into the seat with your hand while tightening the seat belt or LATCH strap. When the car seat is installed, be sure it does not move more than an inch side to side or toward the front of the car.
- If you install the car seat using your vehicle's seat belt, you must make sure the seat belt locks to keep a tight fit. In most newer cars, you can lock the seat belt by pulling it all the way out and then allowing it to retract to keep the seat belt tight around the car seat. Many car seats have built-in lock-offs to lock the belt. Check your vehicle owner's manual and car seat instructions to make sure you are using the seat belt correctly.
- It is best to use the tether that comes with your car seat to the highest weight allowed by your vehicle and the manufacturer of your car seat. Check your vehicle owner's manual and car seat instructions for how and when to use the tether and lower anchors.

Figure 3. Convertible car safety seat used rear facing.

Has your child outgrown the forward-facing seat?

- All children whose weight or height is above the forward-facing limit for their car seat should use a belt-positioning booster seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are 8 through 12 years of age.
- A seat belt fits properly when the shoulder belt lies across the middle of the chest and shoulder, not the neck or throat; the lap belt is low and snug across the upper thighs, not the belly; and the child is tall enough to sit against the vehicle seat back with her knees bent over the edge of the seat without slouching and can comfortably stay in this position throughout the trip.

Do you have the instructions for the car seat?

- Follow them and keep them with the car seat.
- Keep your child in the car seat until she reaches the weight or height limit set by the manufacturer. Follow the instructions to determine whether your child should ride rear facing or forward facing and whether to install the seat using LATCH or the vehicle seat belt.

Figure 5. Belt-positioning booster seat.

Has the car seat been recalled?

- You can find out by calling the manufacturer or the National Highway Traffic Safety Administration (NHTSA) Vehicle Safety Hotline at 888/327-4236 or by going to the NHTSA Web site at www.safercar.gov.
- Follow the manufacturer's instructions for making any repairs to your car seat.
- Be sure to fill in and mail in the registration card that comes with the car seat. You can also register your seat on the manufacturer's Web site. It will be important in case the seat is recalled.

Figure 6. Lap and shoulder seat belt.

Do you know the history of your child's car seat?

- Do not use a used car seat if you do not know the history of the seat.
- Do not use a car seat that has been in a crash, has been recalled, is too old (check the expiration date or use 6 years from date of manufacture if there is no expiration date), has any cracks in its frame, or is missing parts.
- Make sure it has labels from the manufacturer and instructions.
- Call the car seat manufacturer if you have questions about the safety of your seat.

Questions

If you have questions or need help installing your car seat, find a certified child passenger safety technician (CPST). Lists of certified CPSTs and child seat-fitting stations are available on the following Web sites:

- https://www.nhtsa.gov/parents-and-caregivers - NHTSA Vehicle Safety Hotline 888.327.4236
- https://www.nhtsa.gov/equipment/car-seats-and-booster-seats
- https://cert.safekids.org/
- SeatCheck – 1.866.SEATCHECK (1.866.732.8243)
- National Child Passenger Safety Certified Technicians 1.877.366.8154. They also provide information in Spanish and a list of CPS technicians with enhanced training in protection of children with special needs.

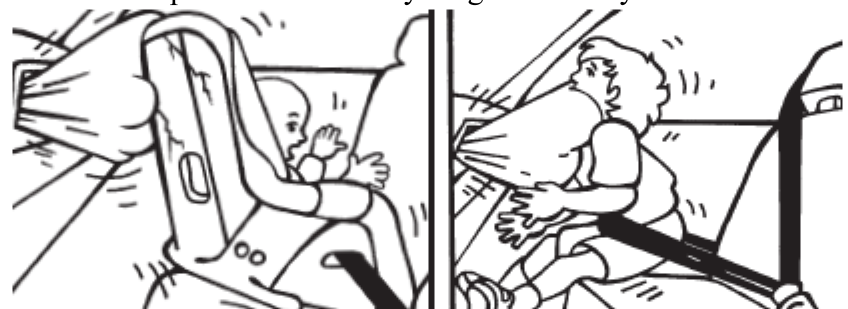
Air Bag Safety

An air bag can save your life. However, air bags and young children are a dangerous combination.

The following information will help keep you and your children safe:

- The safest place for all infants and children younger than 13 years to ride is in the back seat.
- Never put an infant in the front seat of a car, truck, SUV, or van with a passenger air bag.
- All children should be properly secured in car safety seats, belt-positioning booster seats, or the lap and shoulder belts correct for their size.
    - All infants and toddlers should ride in a rear-facing car seat as long as possible or until they reach the highest weight or height allowed by their car safety seat's manufacturer.
    - All children who have outgrown the rear-facing weight or height limit for their car safety seat, should use a forward-facing car safety seat with a harness for as long as possible, up to the highest weight or height allowed by their car safety seat's manufacturer.
    - All children whose weight or height is above the forward-facing limit for their car safety seat should use a belt-positioning booster seat until the vehicle seat belt fits properly, typically when they have reached 4 feet 9 inches in height and are between 8 and 12 years of age.
    - When children are old enough and large enough to use the vehicle seat belt alone, they should always use lap and shoulder seat belts for optimal protection.

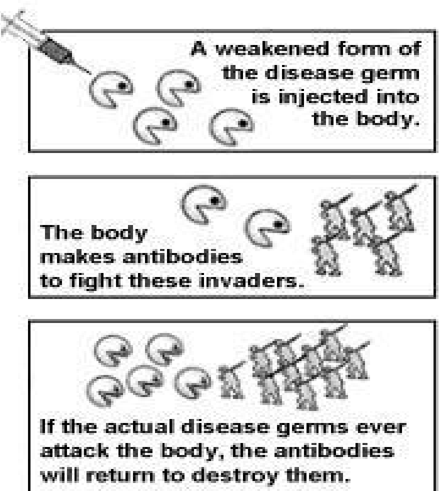
- Side air bags improve safety for adults in side impact crashes, but children who are not properly restrained and are seated near a side air bag may be at risk for serious injury. Check your vehicle owner's manual to see what it says about children and side air bags.
- New "advanced" air bags make travel safer for adults, but it is not yet known how they will affect the safety of children. Even though these new air bags may be safer, the back seat is still the safest place for children younger than 13 years to ride.



What parents can do:

- Eliminate potential risks of air bags to children by buckling them in the back seat for every ride.
- Plan ahead so that you do not have to drive with more children than can be safely restrained in the back seat.
- For most families, installation of air bag on/off switches is not necessary. Air bags that are turned off provide no protection to older children, teens, parents, or other adults riding in the front seat.
- Air bag on/off switches should only be used if your child has special health care needs for which your pediatrician recommends constant observation during travel and no other adult is available to ride in the back seat with your child.
- If no other arrangement is possible and an older child must ride in the front seat, move the vehicle seat back as far as it can go, away from the air bag. Be sure the child is restrained properly for his size. Keep in mind that your child may still be at risk for injuries from the air bag. The back seat is the safest place for children to ride.

Why Are Childhood Vaccines So Important?



It is always better to prevent a disease than to treat it after it occurs. Diseases that used to be common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, rotavirus and *Haemophilus influenzae* type b (Hib) can now be prevented by vaccination. Thanks to a vaccine, one of the most terrible diseases in history – smallpox – no longer exists outside the laboratory. Over the years vaccines have prevented countless cases of disease and saved millions of lives.

Immunity Protects us From Disease

Immunity is the body's way of preventing disease. Children are born with an immune system composed of cells, glands, organs, and fluids located throughout the body. The immune system recognizes germs that enter the body as "foreign invaders" (called *antigens*) and produces proteins called *antibodies* to fight them. The first time a child is infected with a specific antigen (say measles virus), the immune system produces antibodies designed to fight it. This takes time . . . usually the immune system can't work fast enough to prevent the antigen from causing disease, so the child still gets sick. However, the immune system "remembers" that antigen. If it ever enters the body again, even after many years, the immune system can produce antibodies fast enough to keep it from causing disease a second time. This protection is called immunity. It would be nice if there were a way to give children immunity to a disease without their having to get sick first. In fact there is:

Vaccines contain the same antigens (or parts of antigens) that cause diseases. For example, measles vaccine contains measles virus. But the antigens in vaccines are either killed, or weakened to the point that they don't cause disease. However, they *are* strong enough to make the immune system produce antibodies that lead to immunity. In other words, *a vaccine is a safer substitute for a child's first exposure to a disease*. The child gets protection without having to get sick. Through vaccination, children can develop immunity without suffering from the actual diseases that vaccines prevent.

More Facts

- Newborn babies are immune to many diseases because they have antibodies they got from their mothers. However, this immunity goes away during the first year of life.
- If an unvaccinated child is exposed to a disease germ, the child's body may not be strong enough to fight the disease. Before vaccines, many children died from diseases that vaccines now prevent, such as whooping cough, measles, and polio. Those same germs exist today, but because babies are protected by vaccines, we don't see these diseases nearly as often.
- Immunizing individual children also helps to protect the health of our community, especially those people who cannot be immunized (children who are too young to be vaccinated, or those who can't receive certain vaccines for medical reasons), and the small proportion of people who don't respond to a particular vaccine.
- Vaccine-preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and premature deaths. Sick children can also cause parents to lose time from work.

Your Child's Vaccine Visit

There are things that parents can do before, during, and after vaccine visits to make them easier and less stressful.

Before the Visit: Come prepared! Take these steps before your child gets a shot to help make the immunization visit less stressful on you both.

- Read any vaccine materials you received from your child's healthcare professional and write down any questions you may have.
- Learn more about the benefits and risks of the vaccines that your child will receive by reviewing Vaccine Information Statements provided in this book as well as at each vaccine appointment.
- Help your child see vaccines as a good thing. Never threaten your child with shots by saying, "If you misbehave I will have the nurse give you a shot." Instead, remind children that vaccines can keep them healthy.
- Find your child's personal immunization record and bring it to your appointment. An up-to-date record tells your doctor exactly what shots your child has already received.
- Pack a favorite toy or book or a blanket that your child uses regularly to comfort your child.
- A mild illness is usually not a reason to reschedule a vaccination visit.

For older children

- Be honest with your child. Explain that shots can pinch or sting, but that it won't hurt for long.
- Engage other family members, especially older siblings, to support your child.
- Avoid telling scary stories or making threats about shots.
- Remind children that vaccines can keep them healthy.

At the Doctor's Office

If you have questions about immunizations, ask your child's doctor or nurse. Your child's doctor will give you Vaccine Information Statements (VIS) for the shots that your child will be getting

that day. VIS include information about the risks and benefits of each vaccine. If your doctor doesn't give you one you can request one.

For babies and younger children

Try these ideas for making the shots easier on your child.

- Distract and comfort your child by cuddling, singing, or talking softly.
- Smile and make eye contact with your child. Let your child know that everything is ok.
- Comfort your child with a favorite toy or book. A blanket that smells familiar will help your child feel more comfortable.
- Hold your child firmly on your lap, whenever possible. Learn more about how to hold your child during shots.

Ways to soothe your baby

- Swaddling
- Skin-to-skin contact
- Offer a sweet beverage like juice (when the child is older than 6 months)
- Breastfeeding

Once your child has received all of the shots, be especially supportive. Hold, cuddle, and for infants, breastfeed or offer a bottle. A soothing voice, combined with praise and hugs will help reassure child that everything is okay.

For older children and adolescents

- Take deep breaths with your child to help "blow out" the pain.
- Point out interesting things in the room to help create distractions.
- Tell or read stories.
- Support your child if he or she cries. Never scold a child for not "being brave."

Remember to schedule your next visit! Stay current with your child's immunizations for the best protection against disease.

Fainting (syncope) can be common among adolescents immediately after getting shots. To help prevent any injuries that could occur from a fall while fainting, your preteen or teen should stay seated for 15 minutes after the shot. Learn more about fainting.

Before you leave the appointment, ask your child's doctor for advice on using non-aspirin pain reliever and other steps you can take at home to comfort your child.

After the Shots

Sometimes children experience mild reactions from vaccines, such as pain at the injection site, a rash or a fever. These reactions are normal and will soon go away. The following tips will help you identify and minimize mild side effects.

- Review any information your doctor gives you about the shots, especially the Vaccine Information Statements or other sheets that outline which side effects might be expected.
- Use a cool, wet cloth to reduce redness, soreness, and swelling in the place where the shot was given.

  Take a moment to read the Vaccine Information Sheet you will receive during your visit. This sheet has helpful information and describes possible side effects your child may experience.
- Reduce any fever with a cool sponge bath. If your doctor approves, give non-aspirin pain reliever.
- Give your child lots of liquid. It's normal for some children to eat less during the 24 hours after getting vaccines.
- Pay extra attention to your child for a few days. If you see something that concerns you, call your doctor.

Vaccines When Your Child Is Sick

Children with mild illness may still get vaccines – even if they have a fever. A mild illness is usually not a reason to reschedule vaccinations. Your doctor can help you decide which vaccines your child can still receive safely.

Doctors at the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics, and the American Academy of Family Physicians recommend that children with mild illnesses can usually receive their vaccinations on schedule. Mild illness does not affect how well the body responds to a vaccine.
Mild illnesses include:

- Low grade fever (less than 101 degrees Fahrenheit)
- A cold, runny nose or cough
- Ear infection (otitis media)
- Mild diarrhea

There is no health benefit to waiting to vaccinate your child if he or she has a mild illness.

Vaccines do not make a mild illness worse

Vaccines do not make symptoms of illness worse – though they may cause mild side effects.
These may include:

- Low grade fever
- Soreness or swelling where the shot was given

To help with discomfort from these side effects, try one of these tips:

- Put a cool, wet washcloth on the sore area
- Ask your child's doctor about using pain- or fever-reducing medicine.

Children taking antibiotics can get vaccines

Antibiotics will not affect how your child's body responds to vaccines. Children taking antibiotics for a mild illness should not delay vaccines.

Serious illness may affect the vaccines your child gets

Children with moderate or serious illness—with or without fever—may need to wait until they are better to get some vaccines.

Your child may not receive some vaccines if he or she has:

- A chronic health condition (like cancer)
- A weakened immune system (like if undergoing chemotherapy or taking certain medications after a transplant)
- Had a severe allergic reaction to previous dose of a vaccine or an ingredient in a vaccine

If your child has a serious illness or medical condition, talk to your child's doctor or nurse. They can help to determine which vaccines your child can and cannot get at each visit and how to best protect your child's health.

International Adoption: Health Guidance and the Immigration Process

Information for Parents, Adoption Providers, and Clinicians

Each year, parents in the United States adopt more than 5,000 children from all over the world. Adopting a child is a wonderful and exciting event for families. The health of the adopted child is one of many issues that parents need to address during the adoption process. Parents should be prepared for possible challenges during the adoption process and be aware that sometimes the process can be lengthy.

Children born in other areas of the world may have different health problems from those of children raised in the United States. Children may have been exposed to vaccine-preventable diseases that are rare in the United States. Some children are adopted from countries with high rates of diseases, such as tuberculosis, hepatitis, and HIV/AIDS. For all these reasons, knowing as much as possible about a child's health will help parents get the right treatment and care for their child. Ensuring that adopted children are healthy will also help prevent the spread of disease in families and communities in the United States.