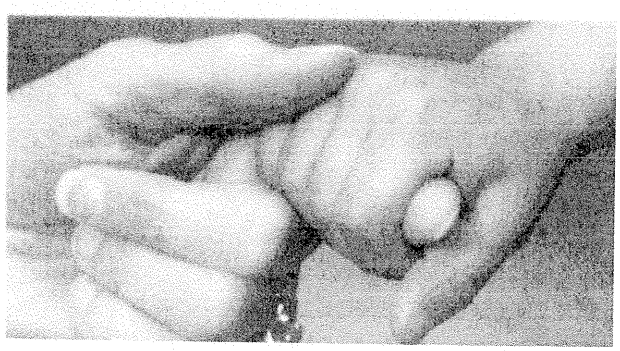
CELEBRATING 30 YEARS



M.D. PEDIATRIC CENTER

OMAR SAWLANI, M.D.
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ANTICIPATORY PARENTING GUIDE

FOR AGE: 18 Months

M.D. PEDIATRIC CENTER
OMAR SAWLANI, MD

SCHEDULED PREVENTATIVE CARE

AGE		SCREENING	IMMUNIZATIONS
0-2 Wks			Hep B
1 Mos.	Check-up	Edenburg	
2 Mos.	Check-up		DTaP; IPV;Rotarix Prevnar; HIB/Hep B
4 Mos.	Check-up	Edenburg	DTaP; IPV;Rotarix Prevnar; HIB/Hep B
6 Mos.	Check-up	ASQ	DTaP; Prevnar; HIB/Hep B
9 Mos.	Check-up	Denver II; hemoglobin; Lead Screen; Sickle Cell	
12 Mos.	Check-up	ASQ-SE; PPD	Varivax; Prevnar:Hep A
15 Mos.	Check-up	Denver II	MMR
18 Mos.	Check-up	ASQ-SE	DTaP; IPV;Hib;HepA;Lead
24 Mos.	Check-up	ASQ-SE	
30 Mos.	Check-up	ELM	
3 Yrs.	Check-up	ASQ	
4 Yrs.	Check-up	Hearing; Vision	DTaP; IPV
5 Yrs.	Check-up	Hgb; UA; Vision	MMR ; Varivax
6–13 Yrs.	Annual Check-up (Around birthday)		
11 Yrs.	Check-up		Meningitis
14 Yrs.	Check-up		Td
15-18 Yrs.	Annual Check-up (Around birthday)		

Topics in this Guide:

-Anticipatory Guide
-Passive Smoking
-Night Awakening in Infants
-What should I Keep in my medicine cabinet
- DTAP vaccine info
- IPV vaccine info
-HEP B vaccine info
-HIB vaccine info

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ANTICIPATORY GUIDE - 18 MONTHS

INJURY PREVENTION

- Ensure stair and window safety. Railing guards, gates, and window locks.
- Use car restraints consistently.
- Supervise all play, especially in driveway. Children of this age do not understand danger or remember "no".
- Never leave a child unattended in a car or alone in the house.
- Guard against falls. Do not leave a chair so that the child can use it to climb to a dangerously high place.
- Guard against electrical injuries from electrical cords or unprotected outlets.
- Never leave the toddler unsupervised in or near a swimming pool, bathtub, ditch, well, or bathroom.

GOOD PARENTING PRACTICES

- Do not expect your child to share toys with other children.
- Buy durable toys (without small parts) that the child can take apart, put together, or use to build (nesting toys, blocks).
- Your child will be interested in the contents of drawers, cabinets, and wastebaskets.
- Read bedtime stories to the child regularly to enrich verbal expressions. Increase interest in the spoken language and enhance listening skills.
- Promote play, both quiet and active. "Pretend play" and dramatic play are to be encouraged.
- Assign simple household chores (picking up toys).
- Praise your child when they are behaving well.

NUTRITION

Make mealtime a regular family gathering and at a time for conversations. Discourage snacking as much as possible. Your child's food likes and dislikes are changing at this age. The child's food requirements are not large.

SLEEP

Keep the bedtime rituals short. A child at this age may take two naps or none at all. Night awakening - approximately 10% -15% of children have problems sleeping through the night. If your child fits this description, see attached sheet on Night Awakening in Older Infants. At times, your child may resist going to bed. If this occurs often, read the attached sheet on Bedtime Resistance.

DISCIPLINE

Allow your child to make some choices; autonomy and independence enhance the sense of competence. Set limits through verbal prohibitions.

Reinforce self care and self expression. Praise what the child does for himself (placing his hand in his sleeve, putting meat on a fork, inserting a proper piece in a puzzle, drying himself after a bath). A child is highly pleased by parental approval.

SELF COMFORTING BEHAVIORS

Thumb-sucking, the use of a favorite toy, teddy bear or blanket and masturbation are age-appropriate ways of handling stress or tension. See attached sheet on Thumb-Sucking and sheet on Masturbation in Pre-Schoolers.

DEFINITION

Approximately 10% to 15% of children between 4 months and 24 months of age have problems sleeping through the night. They wake up and cry one or more times during the night in order to be fed or entertained by their parents. These interruptions usually occur every night. In most instances the child has behaved this way since birth. If your child fits this description, the information presented here will help you understand the problem and take steps to establish a normal nighttime sleeping pattern.

All children have four or five partial awakenings each night after dreams. Most can put themselves back to sleep. Children who have not learned self-comforting and self-quieting skills cry for a parent. If your custom at naps and bedtime is to rock or feed your child until asleep, your infant will not learn how to go back to sleep without your help.

Trained Night Feeders

If your child is over 4 months of age and wants to be fed during the night, deal with this problem first. From birth to 2 months of age, most babies normally awaken twice each night for feedings. Between 2 and 3 months, most need one middle-of-the-night feeding. By 4 months of age, about 90% of infants sleep more than 8 consecutive hours without feeding. Normal children of this age do not need any calories during the night to remain healthy. The other 10% can learn to sleep through the night if you take the following steps:

1. **Lengthen the time between daytime feedings to 4 hours or more.** Nighttime feeding intervals cannot be extended if the daytime intervals are short. If a baby's stomach is conditioned to expect frequent feedings during the day, he will have hunger pangs during the night. This bad habit is called "grazing." It often happens to mothers who don't separate holding from nursing. For every time you nurse your baby, there should be four or five times that you snuggle your baby without nursing. Gradually postpone daytime feeding times until they are more normal for your child's age. If you currently feed your baby hourly, go to 1½ hours. When this is accepted, go to 2 hours. When he cries, provide cuddling or a pacifier. Your goal for formula-fed babies is four meals each day by 4 months of age. (Breast-fed babies often need five feedings each day until 6 months of age when baby foods are introduced.)

2. **Place your baby in the crib drowsy but awake.** When your baby starts to act drowsy, stop feeding him and place him in the crib. His last waking memory needs to be of the crib, not of the breast or bottle. He needs to learn to put himself to sleep. He will need this self-quieting skill to cope with normal awakenings at night. This change will require some crying. For crying, go to your child every 15 minutes, but don't feed him or lift him out of the crib. Give him a hug and leave. Stay for less than 1 minute. Help him learn to self-initiate sleep at naps and bedtime when you can better tolerate the crying. For middle-of-the-night crying, you can rock him to sleep for now.

3. **Discontinue any bottle in bed immediately.** If you feed your child at bedtime, don't let her hold the bottle. Also feed her in a different room than the bedroom. Try to separate mealtime and nap times. If your baby needs to suck on something to help her go to sleep, offer a pacifier or help her find a thumb. Also, encourage attachment to a favorite stuffed animal or blanket.

4. **Phase out night feedings.** For now, after the 10 or 11 PM last feeding of the day, only feed your baby once during the night and make it brief and boring. If it takes more than 20 minutes, handling or burping is excessive. For other awakenings at night, rock your child to sleep.

After the daytime feeding intervals are normal, start to gradually reduce the amount you feed your baby at night. For bottle-fed babies, the amount of formula you give can be decreased by 1 ounce every few nights until your infant no longer has a craving for food at night. Nurse breast-fed babies on just one side and for fewer minutes.

Trained Night Criers

If your baby is over 4 months of age, cries during the night, calms down when you hold her, and doesn't need to be fed, you have a trained night crier. If you usually rock, cuddle, or walk your baby at the moment of sleep, he becomes unable to return himself to sleep during normal awakenings at night.

1. **Place your baby in the crib drowsy but awake at naps and bedtime.** It's good to hold babies. But when your baby starts to look drowsy, place him in the crib. His last waking memory needs to be of the crib, not of you. He needs to learn to put himself to sleep. If your baby is very fussy, rock him until he settles down or is almost asleep, but stop before he's fully asleep.

2. **For crying, make brief contact every 15 minutes.** Infants cannot learn to self-comfort without some crying. This crying is not harmful. If the crying continues, visit your baby in the crib every 15 minutes. Don't stay longer than 1 minute. Act sleepy. Whisper, "Shhh, be quiet, everyone's sleeping." Add a few reassuring comments and give some gentle pats. Do not turn on the lights or remove your child from the crib. Do not rock or play with the baby, bring her to your bed, or stay in the room for more than 1 minute. Most young infants will cry for 30 to 90 minutes and then fall asleep. If the crying persists, you may recheck your baby every 15 minutes, for 1 minute or less each visit. This brief contact will not reward your baby sufficiently to perpetuate the behavior.

3. **For middle-of-the-night crying, rock your baby to sleep temporarily.** Until your child learns how to put himself to sleep at naps and bedtime, make the middle of the night as easy as possible. Take your crying child out of the crib and rock him to sleep. However, don't talk to him, leave the room, or turn on the lights. After he has learned to quiet himself for naps and bedtime, you can place the same demands on him for middle-

(Continued on the reverse side)

of-the-night crying. Namely, go to him every 15 minutes—but make your contact brief and boring. By then, this problem can be turned around in a few nights.

Fearful Night Criers

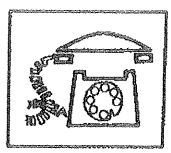
After 6 months of age, the normal separation fears of many infants are greater at bedtime and during the night. When you try to leave your child's bedroom, he becomes hysterical, cries nonstop for hours, or cries until he vomits. If your child is between 6 and 18 months of age and has major daytime fears when you leave him, treat his sleep problem as follows:

1. **Stay with your child if he is fearful.** At bedtime and naptime, put your child in the crib drowsy but awake. Stay as long as it takes to calm him, but don't lift him out of the crib. At the most, sit in a chair next to the crib with your hand on his body. A headphone with some good music may help you pass the time. Make a few reassuring comments initially, and then don't talk to him. If it's the middle of the night, consider going to sleep in your child's room in a sleeping bag.
2. **Leave briefly every 15 minutes.** Leave for 1 or 2 minutes every now and then to teach your child that separation is tolerable because you do come back. Leave the door open and a night-light on if your child has separation fears.
3. **Provide lots of holding during the day.** During the day, respond to your child's fears with lots of hugs and comforting. Young babies may need more time being carried about in a front sling or backpack. Children of mothers working outside the home need extra attention and cuddling in the evenings. Also, play separation games such as peekaboo, hide-and-seek, or chase me. Fears and insecurities can be completely treated during the day.

Steps To Take for All Types of Sleep Problems

Whether your baby's problem is trained night feeding, trained night crying, or fearful night crying, the following measures should be helpful:

1. **Move the crib to another room.** If the crib is in your bedroom, move it to a separate room. If this is impossible, cover one of the side rails with a blanket so your baby can't see you when he awakens.
2. **Eliminate long daytime naps.** If your baby has napped for more than 2 hours, awaken her. If she is in the habit of taking three naps during the day, try to change her habit to two naps each day.
3. **Don't change wet diapers during the night.** Change the diaper if it is soiled or if you are treating a bad diaper rash. If you must change your child, use as little light as possible (for example, a flashlight), do it quietly, and don't provide any entertainment.
4. **If he's standing up in the crib, leave him in that position.** Don't try to get him to lie down every time you go in. He will just spring back up as you start toward the door. He can lie down without your help. Encouraging him to lie down soon becomes a game.



CALL OUR OFFICE

During regular hours if
—Your child acts sick.
—Someone in your family cannot tolerate the crying.
—The steps outlined here do not improve your child's sleeping habits within 2 weeks.
—You have other questions or concerns.

Instructions for Pediatric Patients by Barton D. Schmitt, M.D., *Pediatrician*

DEFINITION

—These children are over 2 years old and refuse to go to bed or stay in the bedroom.
—These children can come out of the bedroom because they no longer sleep in a crib.
—In the usual form, the child goes to sleep while watching television with the parent or sleeps in the parents' bed.
—In a milder form, the child stays in his bedroom but prolongs the bedtime interaction with ongoing questions, unreasonable requests, protests, crying, or temper tantrums.
—In the morning, these children sleep late or have to be awakened.

Cause

These are attempts to test the limits, not fear. Your child has found a good way to postpone bedtime and receive extra entertainment. Your child is stalling and taking advantage of your good nature. If given a choice, over 90% of children would stay up until their parents' bedtime. These children also often try to share the parents' bed at bedtime or sneak into their parents' bed during the middle of the night. By contrast, the child who comes to the parents' bed if he is frightened or not feeling well should be supported at these times.

DEALING WITH BEDTIME RESISTANCE

These recommendations apply to children who are manipulative at bedtime, not fearful.

1. **Start the night with a pleasant bedtime ritual.** Provide a bedtime routine that is pleasant and predictable. Most prebedtime rituals last about 30 minutes and include taking a bath, brushing teeth, reading stories, talking about the day, saying prayers, and other interactions that relax your child. Try to keep the same sequence each night because familiarity is comforting for children. Try to have both parents take turns in creating this special experience. Never cancel this ritual because of misbehavior earlier in the day. Before you give your last hug and kiss and leave your child's bedroom, ask, "Do you need anything else?"

2. **Establish a rule that your child can't leave the bedroom at night.** Enforce the rule that once the bedtime ritual is over and your child is placed in the bedroom, he cannot leave that room. Your child needs to learn to put himself to sleep for naps and at bedtime in his own bed. Do not stay in the room until he lies down or falls asleep. Establish a set bedtime and stick to it. Make it clear that your child is not allowed to leave the bedroom between 8:00 at night and 7:00 in the morning (or whatever sleep time you decide on). Obviously, this change won't be accomplished without some crying or screaming for a few nights.

If your child has been sleeping with you, tell him "Starting tonight, we sleep in separate beds. You have your room, we have our room. You have your bed, we have our bed. You are too old to sleep with us anymore."

3. **Ignore verbal requests.** For ongoing questions or demands from the bedroom, ignore them and do not engage in any conversation with your child. All of these requests should have been dealt with during your prebedtime ritual. Don't return or talk with your child unless you think he is sick. SOME EXCEPTIONS: If your child says he needs to use the toilet, tell him to take care of it himself. If your child says his covers have fallen off and he is cold, promise him you will cover him up after he goes to sleep. You will usually find him well covered.

4. **Close the bedroom door for screaming.** For screaming from the bedroom, tell your child, "I'm sorry I have to close your door. I'll open it as soon as you're quiet." If he pounds on the door, you can open it after 1 or 2 minutes and suggest that he go back to bed. If he does, you can leave the door open. If he doesn't, close the door again. For continued screaming or pounding on the door, reopen it approximately every 15 minutes, telling your child that if he quiets down, the door can stay open. Never spend more that 30 seconds reassuring him.

5. **Close the bedroom door for coming out.** If your child comes out of the bedroom, return him immediately to his bed. During this process, avoid any lectures and skip the hug and kiss. Get good eye contact and remind him again that he cannot leave his bedroom during the night. Warn him that if he comes out again, you're sorry but you will need to close the door. If he comes out, close the door. Tell him, "I'll be happy to open your door as soon as you're in your bed." If your child says he's in his bed, open the door. If he says nothing, every 10 to 15 minutes, open the door just enough to ask your child if he's in his bed now.

6. **Barricade or lock the bedroom door for repeated coming out.** If your child is very determined and continues to come out of the bedroom, consider putting a barricade in front of his door, such as a strong gate. A half-door or plywood plank may also serve this purpose. If your child makes a ruckus at night, you can go to him without taking him out of his bedroom and say, "Everyone is sleeping, I'll see you in the morning."

If your child learns to climb over the barricade, a full door may need to be kept closed until morning with a hook, piece of rope, or chain lock. While you may consider this step extreme, it can be critical for protecting children less than 5 years old who wander through the house at night without an understanding of dangers (such as the stove, hot water, electricity, knives, and going outdoors).

If your child does not get into trouble at night, you can open the door as soon as he falls asleep. Reassure him that you will do this. Also, each night give him a fresh chance to stay in the bedroom with the door open. (CAUTION: If your child has bedtime fears, don't close his door. Get him some counseling.)

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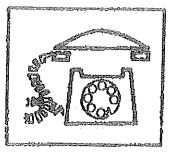
7. **Return him if he comes into your bed at night.** For middle-of-the-night attempts to crawl into your bed, unless your child is fearful, sternly order your child back to his own bed. If he doesn't move, escort him back immediately without any physical contact or pleasant conversation. If you are asleep when your child crawls into your bed, return him as soon as you discover his presence. If he attempts to come out again, temporarily close his door. If you are a deep sleeper, consider using some signaling device that will awaken you if your child enters your bedroom (such as a chair placed against your door or a loud bell attached to your doorknob). Some parents simply lock their bedroom door. Remind your child that it is not polite to interrupt other people's sleep. Tell him that if he awakens at night and can't go back to sleep, he can read or play quietly in his room, but he is not to bother his parents.

8. **Help the roommate.** If the bedtime screaming wakes up a roommate, have the well-behaved sibling sleep in a separate room until the nighttime behavior has improved. Tell your child with the sleep problem that his roommate cannot return until he stays in his room quietly for three consecutive nights. If you have a small home, have the sibling sleep in your room temporarily and this will be an added incentive for your other child to improve.

9. **Praise appropriate sleeping behavior.** Praise your child in the morning if he stayed in his bedroom all night. Tell him that people are happier when they get a good night's sleep. If he fought bedtime and fell asleep late, wake him up at the regular time so he will be tired earlier the next evening.

10. **Start bedtime later if you want to minimize bedtime crying.** The later the bedtime, the more tired your child will be and the less resistance he will offer. For most children, you can pick the bedtime hour. For children who are very stubborn and cry a lot, you may want to start the bedtime at 10 PM (or whenever your child naturally falls asleep). If the bedtime is at 10 PM, start the bedtime ritual at 9:30 PM. After your child learns to fall asleep without fussing at 10 PM, move the bedtime back by 15 minutes every week. In children who can't tell time, you can gradually (over 8 weeks or so) achieve an 8 PM bedtime in this way with many fewer tantrums (this technique was described by Adams and Rickert in 1989). However, don't let your child sleep late in the morning or you won't be able to advance the bedtime.



CALL OUR OFFICE

During regular hours if
- —Your child is not sleeping well after trying this program for 2 weeks.
- —Your child needs to be locked in the bedroom for more than 7 nights.
- —Your child is frightened at bedtime (he probably needs some counseling).
- —Your child has lots of nightmares.
- —Your child also has several discipline problems during the day.
- —You have other questions or concerns.

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DEFINITION

Time-out is a form of discipline used to interrupt unacceptable behavior by isolating a child in a chair or room for a brief period of time. Time-out has the advantage of providing a cooling-off period for both the child and the parent. It gives a child over 2 or 3 years old a chance to think about his misbehavior and feel a little guilty about it. When a child is less than 2 years old, time-out mainly establishes who is in charge.

Misbehaviors that respond best to time-out are aggressive, harmful, or disruptive behaviors that cannot be ignored. Time-out is much more effective than spanking, threatening, or shouting at your child. Time-out is the best form of discipline for many of the irrational behaviors of toddlers. As a child grows older, use of time-outs can gradually be replaced with logical consequences.

CHOOSING A PLACE FOR TIME-OUT

1. **Playpens or cribs.** Playpens or cribs are a convenient place for time-out for older infants. A playpen near a parent is preferable to isolation in another room because most infants are frightened if they are not in the same room as their parent.
2. **Chairs or corners.** An older child can be told to sit in a chair. The chair can be placed facing a corner. Some parents prefer to have their child stand facing the corner.
3. **Rooms with the door open.** Many parents prefer a room for time-out because it offers more confinement than a chair. The most convenient and safest room for time-out is the child's bedroom. Until 2 years of age, most children become frightened if they are put in a room with a closed door. Other ways to confine your child in a room without completely closing him off are a gate, a heavy dresser that blocks the lower part of the door frame, or a piece of plywood that covers the bottom half of the door.
4. **Rooms with the door closed.** Some children will come out of the bedroom just as soon as they are put in. If you cannot devise a barricade, then the door must be closed. You can hold the door closed for the 3 to 5 minutes it takes to complete the time-out period. If you don't want to hold the door, you can put a latch on the door that allows it to be temporarily locked. Be sure not to forget your child. The time-out should not last longer than a few minutes.

HOW TO ADMINISTER TIME-OUT

1. **Deciding the length of time-out.** The time-out should be long enough for your child to think about his misbehavior and learn the acceptable behavior. A good rule of thumb is 1 minute per year of the child's age, with a maximum of 5 minutes. A kitchen timer can be set for the required number of minutes. If your child leaves time-out early ("escapes"), he should be returned to time-out and the timer should be reset. By the age of 6 years, most children can be sent to their room and asked to stay there until they feel ready to behave.
2. **Putting your child in time-out.** If your child misbehaves, briefly explain the rule she has broken and send her to the time-out chair or room. If your child doesn't go immediately, lead or carry her there. Expect your child to cry, protest, or have a tantrum on the way to time-out. Don't lecture or spank her on the way.
3. **Keeping your child in time-out.** Once children understand time-out, most of them will stay in their chair, corner, or room until the time is up. However, you will have to keep an eye on your child. If he gets up from a chair, put him back gently but quickly without spanking him and reset the timer. If your child comes out of the room, direct him back into the room and reset the timer. Threaten to close the door if he comes out a second time. If your child is a strong-willed 2- or 3-year-old and you are just beginning to use time-outs, you may initially need to hold him in the chair with one hand on his shoulder for the entire 2 minutes. Don't be discouraged; this does teach him that you mean what you say. If your child yells or cries during time-out, ignore it. The important thing is that he remain in time-out for a certain amount of time. Your child will not be able to understand the need for quietness during time-out until at least 3 years of age, so don't expect this of him before then.
4. **Ending the time-out.** Make it clear that you are in charge of when time-out ends. When the time is up, go to your child and state, "Time-out is over. You can get up (or come out) now." Then treat your child normally. Don't review the rule your child broke. Try to notice when your child does something that pleases you and praise her for it as soon as possible.
5. **Practicing time-out with your child.** If you have not used time-out before, explain it to your child in advance. Tell him it will replace spanking, yelling, and other such forms of discipline. Talk to him about the misbehaviors that will lead to time-outs. Also discuss with him the good behavior that you would prefer to see. Then pretend with your child that he has broken one of the rules. Take him through the steps of time-out so that he will understand your directions when you send him to time-out in the future. Also teach your babysitter about time-outs.

DISCIPLINE: PHYSICAL PUNISHMENT

The place of physical punishment in discipline is controversial. There are several good arguments for not using corporal punishment at all. We can raise children to be agreeable, responsible, productive adults without ever spanking them. All children need discipline on hundreds of occasions, but there are alternatives to spanking, such as sending a child to his or her room. Spanking carries the risk of triggering the unrelated pent-up anger that many adults carry inside them. This anger could find an outlet in the spanking and end in child abuse. Parents who turn to spanking as a last resort for "breaking their child's will" may find that they have underestimated their child's determination. In addition, physical punishment worsens aggressive behavior because it teaches a child to lash out when he or she is angry. Other forms of discipline can be more constructive, leaving a child with some sense of guilt and contributing to the formation of a conscience.

If you feel the need occasionally to spank your child, follow these guidelines for safe physical punishment:

—Hit only with an open hand. Hit through clothing. It is difficult to judge how hard you are hitting your child if you hit him or her with an object other than your hand. Paddles and belts commonly cause bruises.

—Hit only on the buttocks, legs, or hands. Hitting a child on the face is demeaning as well as dangerous; in fact, slapping the face is inappropriate at any age.

—Give only one swat; that is enough to change behavior. Hitting your child more than once may relieve your anger but will probably not teach your child anything additional.

—Don't spank children less than 1 year of age. Spanking is inappropriate before your child has learned to walk and should be unnecessary after the age of 5 to 6 years. Use negotiation and discussion to resolve most differences with school-age children.

—Avoid shaking children, because of the serious risk of causing blood clots on the brain (subdural hematomas).

—Don't use physical punishment more than once each day. The more your child is spanked, the less effect it will have.

—Learn alternatives to physical discipline. Isolating a child in a corner or bedroom for a time-out is much more civilized and effective. Learn how to use such forms of discipline.

—Never spank your child when you are out of control, scared, or drinking. A few parents can't stop hitting their child once they start. They can't control their rage and need help for themselves, such as from Parents Anonymous groups. They must learn to walk away from their children and never use physical punishment.

—Don't use physical punishment for aggressive misbehavior, such as biting, hitting, or kicking. Physical punishment under such circumstances teaches a child that it is all right for a bigger person to strike a smaller person. Aggressive children need to be taught restraint and self-control. They respond best to time-outs, which give them an opportunity to think about the pain they have caused.

—Don't allow baby-sitters and teachers to spank your children.

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DEFINITION

A temper tantrum is an immature way of expressing anger. No matter how calm and gentle a parent you are, your child will probably throw some tantrums. Try to teach your child that temper tantrums don't work and that you don't change your mind because of them. By 3 years of age, you can begin to teach your child to verbalize his feelings ("You feel angry because . . . ."). We need to teach children that anger is normal but that it must be channeled appropriately. By school age, temper tantrums should be rare. During adolescence, tantrums reappear, but your teenager can be reminded that blowing up creates a bad impression and that counting to 10 can help him regain control.

RESPONSES TO TEMPER TANTRUMS

Overall, praise your child when he controls his temper, verbally expresses his anger, and is cooperative. Be a good model by staying calm and not screaming or having adult tantrums. Avoid spanking for tantrums because it conveys to your child that you are out of control. Try using the following responses to the different types of temper tantrums.

1. **Support and help children having frustration- or fatigue-related tantrums.** Children often have temper tantrums when they are frustrated with themselves. They may be frustrated because they can't put something together. Young children may be frustrated because their parents don't understand their speech. Older children may be frustrated with their inability to do their homework.

At these times your child needs encouragement and a parent who listens. Put an arm around him and say something brief that shows understanding such as "I know it's hard, but you'll get better at it. Is there something I can do to help you?" Also give praise for not giving up. Some of these tantrums can be prevented by steering your child away from tasks that he can't do well.

Children tend to have more temper tantrums when they are tired (for example, when they've missed a nap) because they are less able to cope with frustrating situations. At these times put your child to bed. Hunger can contribute to temper tantrums. If you suspect this, give your child a snack. Temper tantrums also increase during sickness.

2. **Ignore attention-seeking or demanding-type tantrums.** Young children may throw temper tantrums to get their way. They may want to go with you rather than be left with the baby-sitter, want candy, want to empty a desk drawer, or want to go outside in bad weather. They don't accept rules for their safety. Tantrums for attention may include whining, crying, pounding the floor or wall, slamming a door, or breath holding. As long as your child stays in one place and is not too disruptive, you can leave him alone.

If you recognize that a certain event is going to push your child over the edge, try to shift his attention to something else. However, don't give in to your child's demands. During the temper tantrum, if his behavior is harmless, ignore it completely. Once a tantrum has started, it rarely can be stopped.

Move away, even to a different room; then your child no longer has an audience. Don't try to reason with your child—it will only make the tantrum worse. Simply state, "I can see you're very angry. I'll leave you alone until you cool off. Let me know if you want to talk." Let your child regain control. After the tantrum, be friendly and try to return things to normal. You can prevent some of these tantrums by saying "no" less often.

3. **Physically move children having refusal-type tantrums.** If your child refuses something unimportant (such as a snack or lying down in bed), let it go before a tantrum begins. However, if your child must do something important, such as go to bed or to day care, he should not be able to avoid it by having a tantrum. Some of these tantrums can be prevented by giving your child a 5-minute warning instead of asking him suddenly to stop what he is doing. Once a tantrum has begun, let your child have the tantrum for 2 or 3 minutes. Try to put his displeasure into words: "You want to play some more, but it's bedtime." Then take him to the intended destination (for example, the bed), helping him as much as is needed (including carrying).

4. **Use time-outs for disruptive-type tantrums.** Some temper tantrums are too disruptive for parents to ignore. On such occasions send or take your child to his room for 2 to 5 minutes. Examples of disruptive behavior include

—Clinging to you or following you around during the tantrum
—Hitting you
—Screaming or yelling for such a long time that it gets on your nerves
—Having a temper tantrum in a public place such as a restaurant or church (Move your child to another place for his time-out. The rights of other people need to be protected.)
—Throwing something or damaging property during a temper tantrum

5. **Hold children having harmful or rage-type tantrums.** If your child is totally out of control and screaming wildly, consider holding him. His loss of control probably scares him. Also hold your child when he is having tantrums that carry a danger of self-injury (such as if he is violently throwing himself backward).

Take your child in your arms, tell him you know he is angry, and offer him your sense of control. Hold him until you feel his body start to relax. This usually takes 1 to 3 minutes. Then let him go. This comforting response is rarely needed after 3 years of age.

Some children won't want you to comfort them. Hold your child only if it helps. If your child says "Go away," do so. After the tantrum subsides, your child will often want to be held briefly. This is a good way to get him back into the family activities.

(Continued on the reverse side)

Instructions for Pediatric Patients by Barton D. Schmitt, M.D., *Pediatrician*
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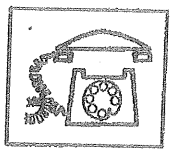

CALL OUR OFFICE

During regular hours if
—Your child has hurt himself or others during tantrums.
—The tantrums occur five or more times per day.
—The tantrums also occur in school.
—Your child has several other behavior problems.
—One of the parents has tantrums or screaming bouts and can't give them up.
—This approach does not bring improvement within 2 weeks.
—You have other questions or concerns.

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DEFINITION

- A child sucks on the thumb or fingers when not hungry.
- A security object, such as a blanket, may become part of the ritual.
- Thumb sucking begins before birth or by 3 months of age at the latest.

Causes

An infant's desire to suck on the breast or bottle is a drive that is essential for survival. More than 80% of babies also do some extra sucking when they are not hungry (non-nutritive sucking). Thumb sucking also helps a child comfort herself. It does not mean that a child is insecure or has emotional problems.

Expected Course

The sucking need is strongest during the first 6 months of a child's life. By 4 years of age, only 15% of children still suck their thumbs. Those children who continue sucking their thumbs after 4 years of age often have become involved in a power struggle with a parent who tried to stop their thumb sucking at too young an age. Occasionally the thumb sucking simply persists as a bad habit. Thumb sucking must be stopped before a child's permanent teeth erupt (6 or 7 years of age), because it can lead to an overbite ("buck teeth").

HOW TO OVERCOME THUMB SUCKING

1. **Before 4 years of age, distract or ignore.** Thumb sucking should be considered normal before the age of 4 years, especially when your child is tired. However, if the thumb sucking occurs when your child is bored and she is over 1 year old, try to distract her. Give her something to do with her hands without mentioning your concern about the thumb sucking. Occasionally praise your child for not thumb sucking. Until your child is old enough for you to reason with her, any pressure or punishment you apply to stop thumb sucking will only lead to increased thumb sucking.
2. **Daytime control.** After 4 years of age, help your child give up thumb sucking during the day. First get your child's commitment to giving up thumb sucking by showing her what thumb sucking is doing to her body. Show her the gap between her teeth with a mirror. Have her look at the wrinkled rough skin (callus) on her thumb. Appeal to her sense of pride. At this point most children will agree that they would like to stop thumb sucking.

   Ask your child if it will be all right if you remind her when she forgets. Do this gently with comments such as "Guess what?" and put an arm around your child as she remembers that she has been sucking on her thumb again. Encourage your child to remind herself by painting a star on her thumb with a Magic Marker, putting a Band-Aid on the thumb, or applying fingernail polish. Your child should put these reminders on herself. Praise your child whenever you notice she is not sucking her thumb in situations where she previously did. Also, give her a reward (such as a dime, a snack, or an extra story) at the end of any day during which she did not suck her thumb at all.
3. **Nighttime control.** After daytime control is established, help your child give up thumb sucking during sleep. Thumb sucking during naps and night is usually an involuntary process. Your child can be told that although the nighttime thumb sucking is not her fault, she can learn not to suck her thumb during sleep by putting something on her thumb to remind her. A glove, sock, splint (thumb guard), or piece of adhesive tape that runs up one side and down the other can be used. Your child should be in charge of putting on whatever material is used to prevent thumb sucking or asking you for assistance. Help your child look on this method as a clever idea rather than any kind of penalty.
4. **Bitter-tasting medicines.** Consider using bitter-tasting medicines if your child is over 4 years of age. A recent study by Dr. P. C. Friman demonstrated a high success rate in 1 to 3 nights using a bitter-tasting solution called Stop-zit (no prescription necessary) in combination with a reward system. Use Stop-zit only if your child is over 4 years old and agrees to use it. Don't use it as a punishment. Present it as a reminder that "other kids like to use it also." Help your child apply Stop-zit only to the thumbnail at the following times: (1) before breakfast, (2) before bedtime, and (3) whenever thumb sucking is observed day or night.

   Look to see whether your child is thumb sucking every 30 minutes after her bedtime until you retire. After 5 nights without thumb sucking, discontinue the morning Stop-zit. After 5 more nights without any thumb sucking, stop using Stop-zit at bedtime. If the thumb sucking recurs, repeat this program.
5. **Dental help.** Bring thumb sucking to the attention of your child's dentist at least by the time your child is 6 years old. Dentists have a variety of approaches to thumb sucking. By the time a child is 7 or 8 years old, dentists can place a reminder bar in the upper part of the mouth that interferes with the ability to suck. This helpful appliance does not cause any pain to your child but may spare you the later economic pain of $4000 worth of orthodontic treatment.

Babies vary in how much extra sucking they do when they are not feeding. This extra sucking is a beneficial self-comforting behavior. Some babies almost constantly suck on their thumb or fingers. If you have a baby like this, you may want to try to interest him in a pacifier. The pacifier has to be introduced during the first month or two of life for it to be accepted as a substitute for the thumb. Although the orthodontic type of pacifier is preferred because it prevents tongue thrusting during sucking, the regular type usually causes no problems. By trial and error, let your baby find the shape he prefers.

ADVANTAGES OF A PACIFIER OVER THUMB SUCKING

The main advantage of a pacifier is that if you can get your child to use one, he usually won't be a thumb sucker. Thumb sucking can cause a severe overbite if it is continued after the permanent teeth come in. The pacifier exerts less pressure on the teeth and causes much less overbite than the thumb. In addition, the pacifier's use can be controlled as your child grows older. You can decide when it's reasonable to discontinue it. By contrast, thumb sucking can't be stopped when you want it to, because the thumb belongs to your child.

WHEN TO OFFER THE PACIFIER

The peak age for sucking is 2 to 4 months. During the following months, the sucking drive normally decreases. A good age to make the pacifier less available is when your child starts to crawl. A pacifier can interfere with normal babbling and speech development. This is especially important after 12 months of age when speech should develop rapidly. It's hard to talk with a pacifier in your mouth. To prevent problems with pacifiers, make sure your child doesn't become overly attached to one (e.g., walks around with one in his mouth.) Consider the following recommendations for preventing excessive use and a "pacifier habit":

- During the first 6 months of life, give it to your baby whenever he wants to suck, but don't offer it whenever your baby cries. Crying has a number of causes besides hunger and sucking.
- When your older infant is stressed, first try to hold and cuddle him rather than using the pacifier for this purpose. Some infants like massage. Try not to overuse the pacifier while you are comforting him.
- After 6 months of age (or when your infant starts crawling), keep the pacifier in your child's crib. He can use it for naptime and bedtime. After your infant falls asleep, remove it from his mouth if it doesn't fall out. If you allow him to use it all the time, his interest in it will increase rather than decrease. If your child seems to want a security object while awake, offer him alternatives such as a stuffed animal.
- ***Reminder:*** If your baby likes the pacifier, don't forget to take it with you when you travel. Keeping a spare pacifier in the car is helpful. For air travel, sucking or swallowing fluids during descent can prevent ear pain.

PACIFIER SAFETY

Some cautions regarding the pacifier should be observed.

- Use a one-piece commercial pacifier, not a homemade one. Don't try making one yourself by taping a nipple to a plastic bottle cap. A homemade pacifier can be pulled apart, become caught in your baby's throat, and cause choking.
- Don't put the pacifier on a string around your baby's neck. The string could strangle your baby. The new "catch-it-clips" that attach the pacifier to your child's clothing on a short ribbon are practical and safe.
- Don't use pacifiers with a liquid center. (Some have been found to be contaminated with germs.)
- Don't coat it with any sweets, which may cause dental cavities if teeth have erupted.
- Don't coat it with honey, which may cause a serious disease called botulism in children less than 1 year of age.
- Rinse off the pacifier each time your baby finishes using it or if it drops to the floor.
- Replace the pacifier if it becomes damaged.

STOPPING USE OF THE PACIFIER

If the pacifier's use has been restricted to naptime and bedtime, many toddlers lose interest in it between 12 and 18 months of age. If your child continues to need the pacifier, you can introduce the idea of giving it up completely by 3 or 4 years of age. Pick a time when your child is not coping with new stresses or fears. Sometimes giving it up on a birthday, holiday, or other celebration makes it easier.

Make the transition as pleasant as possible. Sometimes incentives are needed. If your child seems especially attached to it, help him give it up at naptime first. Use a star chart to mark his progress. When that goal is accomplished, offer to replace the nighttime pacifier with a new stuffed animal or encourage him to trade it for something else he wants. Never force him to give up the pacifier through punishment or humiliation. Abruptly removing the pacifier without preparation can be psychologically harmful.

Give your child a choice such as throwing it away or leaving it out for Santa Claus or the "pacifier fairy." Saving it somewhere in the house is usually not a good idea, because your child will be more likely to ask for it during periods of stress. At such times, offer to cuddle your child instead. Help your child talk about how he misses the pacifier. Praise your child for this sign of growing up.

Some Dos

—Change your child frequently.
—Teach your child to come to you when he needs to be changed.
—Help your child spend time with children who are trained and watch them use the toilet or potty chair.
—Read toilet-learning books to your child.
—Initially, keep the potty chair in the room your child usually plays in. This easy access markedly increases the chances he will use it without your asking him to. Consider owning two potty chairs.
—Teach him how the toilet works.
—Mention using the toilet or potty chair only if your child gives a cue that he needs to go.
—Give suggestions, not demands.
—Give your child an active role and let him do it his way.
—Be supportive.
—Keep a sense of humor.
—Keep the process fun and upbeat. Be positive about any interest your child shows.

Some Don'ts

—Don't start when your child is in a stubborn or negative phase.
—Don't use any punishment or pressure.
—Don't force your child to sit on a potty chair.
—Don't keep your child sitting on a potty chair against his will.
—Don't flush the toilet while your child is sitting on it.
—Don't lecture or remind your child.
—Avoid any friction.
—Avoid battles or showdowns.
—Don't try to control what you can't control.
—Never escalate your response, you will always lose.
—Don't act overconcerned about this normal body function. Try to appear casual and relaxed during the training.
—After your child uses the toilet, don't expect a perfect performance. Some accidents occur for months.

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A Toddler's Toy Box

Toddlers love toys that give them chances to practice their new skills in movement, thinking, and interacting with others.

Here is a list of low-cost, easy-to-find toys and materials for your toddler's toy box!

Movement

- Walker wagon or ride on toy (with a push handle for early walkers)
- A pull toy (string must be less than 12 inches long)
- Big bouncy balls

Using hands

- Blocks (made of wood, plastic, or recycled milk cartons or boxes)
- A shape sorter, nesting cups, simple puzzles
- Dump and fill containers (use recycled plastic containers)
- Scrap paper, old magazines, grocery bags, carry-along notebook
- Crayons
- An old set of keys
- A flashlight
- Edible play dough

Water play

- Squeeze bottles
- Sponges
- Plastic cups
- Soap crayons

Pretend play

- Parent's old clothes for dress-up
- A toy phone
- Plastic kitchen utensils, empty cereal boxes, milk cartons, spoons
- Dollies, bottles, blankies
- A mirror
- A toy tool set
- Toy vehicles

Music

- A drum, or old pots and pans
- Musical tapes
- Sing-along videos
- A child's tape player

Language

- Sturdy, colorful board books

FEARS

"No Doctor, No Doctor"
When Your Child Is Afraid of the Primary Care Clinician

It is very common for toddlers to be upset and afraid of "going to the doctor's." Some children are mildly anxious and manage to get through a visit without falling apart. Others are truly terrified and with good reason. They have probably had uncomfortable and painful things happen at other visits, and now they are old enough to remember. No wonder your child cries in protest!

How can you and your primary care clinician help your child to feel OK?

- **DON'T tease or make fun of your child.** Your child will feel bad for having a normal fear response and things might get worse.
- **DO talk about the visit ahead of time.** Ask your child what she expects will happen. Your child may have fears that won't come true. Let your child know what to expect without focusing too much on any painful procedures. The more your child knows about going to a medical visit the more prepared she will be.
- **DON'T lie.** If your child is going to get a shot, don't tell her she won't. Trust is very important in your relationship. Don't compromise it.
- **DO buy a toy medical kit and help your child master her fears.** Your child can "practice" and puzzle things out before you go to the visit. Bring the kit to the visit and have your primary care clinician and your child take turns being the "doctor."
- **DON'T let your fear or anxiety about medical visits get in the way.** Be upbeat and reassuring. Children can sense anxiety.
- **DO bring comfort objects from home.** Bring a favorite stuffed animal, a security blanket, or a pacifier.
- **DON'T use illness or medical procedures as a threat.** ("If you don't behave, you'll get a shot."). That will make things worse.
- **DO stay with your child during procedures.** Children are usually less fearful when parents are there to comfort them.
- **DO make a plan with your Healthy Steps Team.** If your child does fall apart, decide on a plan of action with the team. Who will comfort? Who will do the procedure? How will the exam get done?

For more information:
The Disney Encyclopedia of Baby and Child Care edited by Judith Palfrey et al., 1999

TOILET TRAINING

IDEAS FOR PARENTS

"We Did It!" Helping to Make Toilet Training a Success

There are many different methods of toilet training children. Children respond to some better than others. What works for one child may not work for another — even if they are siblings! Perhaps the best method for any child is the child-centered approach. A child-centered approach follows the child's lead and is a positive experience for both parent and child. Every child is ready for toilet training at a different time, so if a parent follows the child's lead, the first step in toilet training is knowing when the child is ready. When your child is ready, the following child-centered strategies may help. They are adapted from Steven Parker, MD, and Barry Zuckerman, MD, *Behavioral and Developmental Pediatrics.*

- **Buy a potty chair.** Stress what a wonderful chair it is. Place it in a place where your child can use it. Explain to your child what the chair is for.
- **Help your child get used to the chair.** Let her sit on it — fully clothed — for a few moments a day. Never force her to sit on it. Try to time it for when she is likely to have a bowel movement.
- **Let your child watch you use the bathroom.** Flush the toilet together (if it doesn't scare your child) and say "bye-bye" to the waste.
- **Have your child sit on the potty with her diaper off.** Don't expect results, but if it happens, praise.
- **Together with your child, dump the stool from the diaper into the toilet.** Explain where "the poop" goes. Say "bye-bye" as you flush.
- **Ask your child during the day if she "needs to go potty."** Look for signs that she is about to go. Tell the child "let's take off your pants and go potty." Let your child sit for as long as she wants. Praise success and don't criticize failure.
- **Praise and support your child for attempts and successes.**
- **When you get a regular pattern of urinating and stooling on the potty, ask your child if she is ready to say bye-bye to diapers.** Make a show of throwing them out and putting on "big kid" training pants.
- **Switch to an over-the-toilet-seat chair once training is established.**
- **Nighttime dryness will take some time after success with daytime training.** Check in with your child now and then by asking her if she is ready for training pants at night.

For more information:

Behavioral and Developmental Pediatrics by Steven Parker and Barry S. Zuckerman, 1995
Toilet Training without Tears by Charles E. Schaeffer, Theresa Foy DiGeronimo, and Laura Alexander, 1997

BUSM®: Department of Pediatrics, Boston Medical Center

VACCINE INFORMATION STATEMENT

DTaP Vaccine

(Diphtheria, Tetanus and Pertussis)

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Diphtheria, tetanus, and pertussis are serious diseases caused by bacteria. Diphtheria and pertussis are spread from person to person. Tetanus enters the body through cuts or wounds.

DIPHTHERIA causes a thick covering in the back of the throat.

- It can lead to breathing problems, paralysis, heart failure, and even death.

TETANUS (Lockjaw) causes painful tightening of the muscles, usually all over the body.

- It can lead to "locking" of the jaw so the victim cannot open his mouth or swallow. Tetanus leads to death in up to 2 out of 10 cases.

PERTUSSIS (Whooping Cough) causes coughing spells so bad that it is hard for infants to eat, drink, or breathe. These spells can last for weeks.

- It can lead to pneumonia, seizures (jerking and staring spells), brain damage, and death.

Diphtheria, tetanus, and pertussis vaccine (DTaP) can help prevent these diseases. Most children who are vaccinated with DTaP will be protected throughout childhood. Many more children would get these diseases if we stopped vaccinating.

DTaP is a safer version of an older vaccine called DTP. DTP is no longer used in the United States.

2 Who should get DTaP vaccine and when?

Children should get 5 doses of DTaP vaccine, one dose at each of the following ages:

- 2 months
- 4 months
- 6 months
- 15–18 months
- 4–6 years

DTaP may be given at the same time as other vaccines.

3 Some children should not get DTaP vaccine or should wait

- Children with minor illnesses, such as a cold, may be vaccinated. But children who are moderately or severely ill should usually wait until they recover before getting DTaP vaccine.
- Any child who had a life-threatening allergic reaction after a dose of DTaP should not get another dose.
- Any child who suffered a brain or nervous system disease within 7 days after a dose of DTaP should not get another dose.
- Talk with your doctor if your child:
  - had a seizure or collapsed after a dose of DTaP,
  - cried non-stop for 3 hours or more after a dose of DTaP,
  - had a fever over 105°F after a dose of DTaP.

Ask your doctor for more information. Some of these children should not get another dose of pertussis vaccine, but may get a vaccine without pertussis, called **DT**.

4 Older children and adults

DTaP is not licensed for adolescents, adults, or children 7 years of age and older.

But older people still need protection. A vaccine called **Tdap** is similar to DTaP. A single dose of Tdap is recommended for people 11 through 64 years of age. Another vaccine, called **Td**, protects against tetanus and diphtheria, but not pertussis. It is recommended every 10 years. There are separate Vaccine Information Statements for these vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

5 What are the risks from DTaP vaccine?

Getting diphtheria, tetanus, or pertussis disease is much riskier than getting DTaP vaccine.

However, a vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of DTaP vaccine causing serious harm, or death, is extremely small.

Mild problems (common)

- Fever (up to about 1 child in 4)
- Redness or swelling where the shot was given (up to about 1 child in 4)
- Soreness or tenderness where the shot was given (up to about 1 child in 4)

These problems occur more often after the 4th and 5th doses of the DTaP series than after earlier doses. Sometimes the 4th or 5th dose of DTaP vaccine is followed by swelling of the entire arm or leg in which the shot was given, lasting 1–7 days (up to about 1 child in 30).

Other mild problems include:

- Fussiness (up to about 1 child in 3)
- Tiredness or poor appetite (up to about 1 child in 10)
- Vomiting (up to about 1 child in 50)

These problems generally occur 1–3 days after the shot.

Moderate problems (uncommon)

- Seizure (jerking or staring) (about 1 child out of 14,000)
- Non-stop crying, for 3 hours or more (up to about 1 child out of 1,000)
- High fever, over 105°F (about 1 child out of 16,000)

Severe problems (very rare)

- Serious allergic reaction (less than 1 out of a million doses)
- Several other severe problems have been reported after DTaP vaccine. These include:
  - Long-term seizures, coma, or lowered consciousness
  - Permanent brain damage.

  These are so rare it is hard to tell if they are caused by the vaccine.

Controlling fever is especially important for children who have had seizures, for any reason. It is also important if another family member has had seizures. You can reduce fever and pain by giving your child an *aspirin-free* pain reliever when the shot is given, and for the next 24 hours, following the package instructions.

6 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement

DTaP Vaccine

5/17/2007

42 U.S.C. § 300aa-26

Office Use Only

VACCINE INFORMATION STATEMENT

Polio Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is polio?

Polio is a disease caused by a virus. It enters the body through the mouth. Usually it does not cause serious illness. But sometimes it causes paralysis (can't move arm or leg), and it can cause meningitis (irritation of the lining of the brain). It can kill people who get it, usually by paralyzing the muscles that help them breathe.

Polio used to be very common in the United States. It paralyzed and killed thousands of people a year before we had a vaccine.

2 Why get vaccinated?

Inactivated Polio Vaccine (IPV) can prevent polio.

History: A 1916 polio epidemic in the United States killed 6,000 people and paralyzed 27,000 more. In the early 1950's there were more than 25,000 cases of polio reported each year. Polio vaccination was begun in 1955. By 1960 the number of reported cases had dropped to about 3,000, and by 1979 there were only about 10. The success of polio vaccination in the U.S. and other countries has sparked a world-wide effort to eliminate polio.

Today: Polio has been eliminated from the United States. But the disease is still common in some parts of the world. It would only take one person infected with polio virus coming from another country to bring the disease back here if we were not protected by vaccine. If the effort to eliminate the disease from the world is successful, some day we won't need polio vaccine. Until then, we need to keep getting our children vaccinated.

3 Who should get polio vaccine and when?

IPV is a shot, given in the leg or arm, depending on age. It may be given at the same time as other vaccines.

Children

Children get 4 doses of IPV, at these ages:

- A dose at 2 months
- A dose at 4 months
- A dose at 6-18 months
- A booster dose at 4–6 years

Some "combination" vaccines (several different vaccines in the same shot) contain IPV.

Children getting these vaccines may get one more (5th) dose of polio vaccine. This is not a problem.

Adults

Most adults 18 and older do not need polio vaccine because they were vaccinated as children. But some adults are at higher risk and should consider polio vaccination:

- people traveling to areas of the world where polio is common,
- laboratory workers who might handle polio virus, and
- health care workers treating patients who could have polio.

Adults in these three groups:

- who have **never been vaccinated against polio** should get 3 doses of IPV:
  - Two doses separated by 1 to 2 months, and
  - A third dose 6 to 12 months after the second.
- who have had **1 or 2 doses** of polio vaccine in the past should get the remaining 1 or 2 doses. It doesn't matter how long it has been since the earlier dose(s).
- who have had **3 or more doses** of polio vaccine in the past may get a booster dose of IPV.

Your doctor can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Some people should not get IPV or should wait.

These people should not get IPV:

- Anyone with a life-threatening allergy to any component of IPV, including the antibiotics neomycin, streptomycin or polymyxin B, should not get polio vaccine. Tell your doctor if you have any severe allergies.
- Anyone who had a severe allergic reaction to a previous polio shot should not get another one.

These people should wait:

- Anyone who is moderately or severely ill at the time the shot is scheduled should usually wait until they recover before getting polio vaccine. People with minor illnesses, such as a cold, may be vaccinated.

Ask your doctor for more information.

5 What are the risks from IPV?

Some people who get IPV get a sore spot where the shot was given. IPV has not been known to cause serious problems, and most people don't have any problems at all with it.

However, any medicine could cause a serious side effect, such as a severe allergic reaction or even death. The risk of polio vaccine causing serious harm is extremely small.

6 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)
Polio Vaccine

11/8/2011

42 U.S.C. § 300aa-26

Office Use Only

VACCINE INFORMATION STATEMENT

Hepatitis A Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Informacián Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is hepatitis A?

Hepatitis A is a serious liver disease caused by the hepatitis A virus (HAV). HAV is found in the stool of people with hepatitis A.

It is usually spread by close personal contact and sometimes by eating food or drinking water containing HAV. A person who has hepatitis A can easily pass the disease to others within the same household.

Hepatitis A can cause:

- "flu-like" illness
- jaundice (yellow skin or eyes, dark urine)
- severe stomach pains and diarrhea (children)

People with hepatitis A often have to be hospitalized (up to about 1 person in 5).

Adults with hepatitis A are often too ill to work for up to a month.

Sometimes, people die as a result of hepatitis A (about 3–6 deaths per 1,000 cases).

Hepatitis A vaccine can prevent hepatitis A.

2 Who should get hepatitis A vaccine and when?

WHO

Some people should be routinely vaccinated with hepatitis A vaccine:

- All children between their first and second birthdays (12 through 23 months of age).
- Anyone 1 year of age and older traveling to or working in countries with high or intermediate prevalence of hepatitis A, such as those located in Central or South America, Mexico, Asia (except Japan), Africa, and eastern Europe. For more information see www.cdc.gov/travel.
- Children and adolescents 2 through 18 years of age who live in states or communities where routine vaccination has been implemented because of high disease incidence.
- Men who have sex with men.
- People who use street drugs.
- People with chronic liver disease.
- People who are treated with clotting factor concentrates.
- People who work with HAV-infected primates or who work with HAV in research laboratories.
- Members of households planning to adopt a child, or care for a newly arriving adopted child, from a country where hepatitis A is common.

Other people might get hepatitis A vaccine in certain situations (ask your doctor for more details):

- Unvaccinated children or adolescents in communities where outbreaks of hepatitis A are occurring.
- Unvaccinated people who have been exposed to hepatitis A virus.
- Anyone 1 year of age or older who wants protection from hepatitis A.

Hepatitis A vaccine is not licensed for children younger than 1 year of age.

WHEN

For children, the first dose should be given at 12 through 23 months of age. Children who are not vaccinated by 2 years of age can be vaccinated at later visits.

For others at risk, the hepatitis A vaccine series may be started whenever a person wishes to be protected or is at risk of infection.

For travelers, it is best to start the vaccine series at least one month before traveling. (Some protection may still result if the vaccine is given on or closer to the travel date.)

> Some people who cannot get the vaccine before traveling, or for whom the vaccine might not be effective, can get a shot called immune globulin (IG). IG gives immediate, temporary protection.

Two doses of the vaccine are needed for lasting protection. These doses should be given at least 6 months apart.

Hepatitis A vaccine may be given at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3 Some people should not get hepatitis A vaccine or should wait.

- Anyone who has ever had a severe (life threatening) allergic reaction to a previous dose of hepatitis A vaccine should not get another dose.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine.
- **Tell your doctor if you have any severe allergies**, including a severe allergy to latex. All hepatitis A vaccines contain alum, and some hepatitis A vaccines contain 2-phenoxyethanol.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Tell your doctor if you are pregnant. Because hepatitis A vaccine is inactivated (killed), the risk to a pregnant woman or her unborn baby is believed to be very low. But your doctor can weigh any theoretical risk from the vaccine against the need for protection.

4 What are the risks from hepatitis A vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of hepatitis A vaccine causing serious harm, or death, is extremely small.

Getting hepatitis A vaccine is much safer than getting the disease.

Mild problems

- soreness where the shot was given *(about 1 out of 2 adults, and up to 1 out of 6 children)*
- headache *(about 1 out of 6 adults and 1 out of 25 children)*
- loss of appetite *(about 1 out of 12 children)*
- tiredness *(about 1 out of 14 adults)*

If these problems occur, they usually last 1 or 2 days.

Severe problems

- serious allergic reaction, within a few minutes to a few hours after the shot *(very rare)*.

5 What if there is a serious reaction?

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  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

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Vaccine Information Statement (Interim)

Hepatitis A Vaccine

10/25/2011

42 U.S.C. § 300aa-26

Office Use Only

Dosage for Fever Reducers

Weight		Ibuprofen/Motrin/Advil	Tylenol
Kilograms	Pounds	Children's Syrup 100 mg/5 mL	Children's Syrup 160 mg/5 mL
4.5	10	NOT FOR < 6MOS AGE	2ml
5.5	12	NOT FOR < 6MOS AGE	2.5ml
6.4	14	NOT FOR < 6MOS AGE	3.0ml
7.3	16	3.5 ml	3.5ml
8.2	18	4.0 ml	4.0 ml
9.1	20	4.5ml	4.5ml
10.0	22	5.0ml	5 mL
10.9	24	5.5 mL	5 mL
11.8	26	6 mL	5.5 mL
12.7	28	6.5 mL	6 mL
13.6	30	7 mL	6.5 mL
14.5	32	7.5 mL	7 mL
15.5	34	8 mL	7.5 mL
16.4	36	8.5 mL	7.5 mL
17.3	38	9 mL	8 mL
18.2	40	9 mL	8.5 mL
19.1	42	9.5 mL	9 mL
20.0	44	10 mL	9.5 mL
20.9	46	10.5 mL	10 mL
21.8	48	11 mL	10 mL
22.7	50	11.5 mL	10.5 mL
23.6	52	12 mL	11 mL
24.5	54	12.5 mL	11.5 mL
25.5	56	12.5 mL	12 mL
26.4	58	13 mL	12.5 mL
27.3	60	13.5 mL	13 mL
28.2	62	14 mL	13 mL
29.1	64	14.5 mL	13.5 mL
30.0	66	15 mL	14 mL
30.9	68	15.5 mL	14.5 mL
31.8	70	16 mL	15 mL
32.7	72	16.5 mL	15.5 mL
33.6	74	17 mL	16 mL
34.5	76	17.5 mL	16 mL
35.5	78	18 mL	16.5 mL
36.4	80	18.5 mL	17 mL
37.3	82	19 mL	17.5 mL
38.2	84	19.5 mL	18 mL
39.1	86	20 mL	18.5 mL
40.0	88	20 mL	19 mL