

## **TO THE NEW PARENTS**

Congratulations upon entering one of life's greatest adventures—PARENTHOOD! Although it will be filled with newly acquired responsibilities, frustrations, and concerns, it will at the same time be full of countless joys and immeasurable rewards. Being a good parent requires time, effort and patience, in addition to love. It will be challenging because until you have your own children you cannot appreciate the various demands and situations you will encounter. This is natural—you are not alone.

All of us when we become parents will have many questions arise concerning infant and childcare. If you have other children, your memories of baby days may have faded. Some infant care practices have changed, and you'll want to have up-to-date information. This booklet is a compilation of guidelines concerning this subject. It is not the last word, for there are several approved and accepted approaches to the same problems. Friends, neighbors and relatives are eager to share their knowledge of baby care. But what worked for them may not work for you. And not all of their advice will be correct. So I hope you'll ask me any questions that come to mind while your baby is still in the hospital and afterward - either by phone or during office visits. We feel that our advice combined with your own good common sense will be sufficient for you to handle most problems.

Most parents of children in my practice have many questions about baby care, but they often forget them during the office visit. For this reason, I suggest that you keep a running list of questions at home, even if they seem silly or trivial. Anything that concerns your desire to understand and care for your baby is important for us to discuss.

One of our physicians is on call 24 hours a day to answer urgent questions. Please don't hesitate to call our office if you need us.

I appreciate your asking me to be your baby's physician. I'll do my best to help your baby enjoy a healthy childhood.

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## **ABOUT THIS BOOK**

Pediatrics is a specialty where preventive medicine and anticipatory guidance are a priority. We want to be there to offer you guidance as you take on the challenge of raising a child. Obviously this involves a lot of information.

Most practices use a lot of handouts to convey information that the doctor's feel is important and worth remembering. We are no different. But we want to go a step further. This book is intended to provide a more permanent place to keep that information.

This is not an instruction manual for your child. This is not the Encyclopedia of Child Rearing, or Parenting for Dummies. But it is a selection of answers to frequently asked questions that we get from many new parents. This is a collection of our opinions as physicians. Our advice does not agree with every source of healthcare advice that may be available to you. But it is a collection of our recommendations to you.

It is our hope that you can use this guide when you have worries at odd hours or questions that you do not think are important enough to call us about. However, you should never feel uncomfortable about calling our office or the on-call physician if you have urgent questions. It is our commitment to be available to you as a resource to help you raise your child.

This notebook is only the initial information that we will provide. Each well child visit we will give you additional information to add to this folder relevant to your babies age and developmental stage.

We hope you will find this useful and informative.

Much of this information was derived from the following sources. The information has been modified to reflect our personal recommendations.

McKesson Clinical Reference Systems

Pediatric Advisor 2001.2

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The American Academy of Pediatrics

Health Care Advice for Children, Teens, and Parents

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## GETTING STARTED

When babies go home from the hospital nursery, everyone wants to see them. A new baby generally gets lots of visitors. For a few weeks, limit your baby's visitors, especially children. Newborns become over stimulated and anxious when around a lot of noise or when handled by too many people. I suggest that you keep the baby out of large crowds for a few weeks.

## OFFICE VISITS

The expanse of medical knowledge and understanding in the specialty of Pediatrics has grown immensely in recent years, and is constantly surging ahead with new and exciting information presenting a challenge to the pediatrician. It is our desire to apply our knowledge effectively to provide your baby with the finest comprehensive care and quality of life as he grows and matures, especially throughout his first year.

Please call our office once you are home from the hospital so that we can schedule your baby's first regular appointment at 1 week of age. The doctor may arrange for an appointment sooner if there are special circumstances at the time of birth.

The American Academy of Pediatrics has a recommended schedule of well-child visits that I'd like you to follow during your child's first two years.

### Recommended Office Visits

Age	Reason for visit
1 week	Check-up
1 month	Check-up and vaccines
2 months	Check-up and vaccines
4 months	Check-up and vaccines
6 months	Check-up and vaccines
9 months	Check-up and vaccines
12 months	Check-up, vaccines, and blood work
15 months	Check-up and vaccines
18 months	Check-up and vaccines
24 months	Check-up, vaccines, and blood work

## **OFFICE POLICY**

We are accessible and available to you and your children. We pride ourselves in this matter and we want you to feel free to call and to consult with our office. In many matters a nurse will be able to help you. If you have to speak with the doctor and it is not urgent, leave a message and your phone number. He can return your call in the middle or at the end of the day. Time is extremely valuable for you, the doctor, and the office staff. To interrupt the doctor with his patient flow for a non-emergent call will only cause him a delay and back up in his appointment schedule and patient waiting time. The doctor wants to spend an adequate amount of time with each patient to optimally handle each problem, and will provide the same to you when you are in the office. When the doctor does speak with you, have a pencil and paper ready for taking notes and instructions. Jot down questions so you don't forget something you meant to ask. Be sure the informant knows the history of the problem and can manage the instructions, so everything doesn't have to be repeated. Know the name and phone number of your pharmacy.

If you would like your child to be seen during the day, please state so to our secretaries, and they will arrange an appointment. In our office, an emergency always will take precedent over a more routine or less serious problem. The doctor's judgment will decide what is and what is not a true emergency. Please bear in mind that occasional emergencies will arise in the hospital or nursery, which may cause us to be late seeing your child in the office. We will try to notify you of these circumstances. If you would like to reschedule your child instead of waiting, we certainly understand. If you wish to wait, we will try our very best to see you as soon as possible. We ask your indulgence and cooperation should such emergencies arise. Remember that we would do the same for your child.

## **After Hours Call**

When our office is closed, our phone will be answered by an electronic recording. Please follow its instructions to reach the doctor in the event of an emergency. Please have all information available about your problem when you call, keep paper and pencil ready to write down instructions, and have pharmacy name and number ready in case a prescription is necessary. If the doctor is off-call or out-of-town, another qualified physician will always be available to assist you.

Remember, the doctor is human and has a family also, and must have time for rest, so he or she can provide you with the optimal care that you deserve. If your problem is not an emergency or one that must be managed right away, we would greatly appreciate your consideration with a call during office hours the following morning

# IMMUNIZATIONS

Immunizations have been protecting children from serious diseases for more than 50 years.

When your child is immunized, he receives a vaccine to prevent a certain disease. Vaccines usually are given as shots. The vaccine makes your child's body produce antibodies. These antibodies make him immune to this disease should he ever come in contact with it.

Your child should receive most of her immunizations during the first 2 years of life, starting at birth. Infants and young children are more at risk of being harmed by serious diseases. That is why it is important to begin immunizations early. Your child also will need immunizations before starting school. In addition, she will need to receive vaccines as an older child and teenager.

Today children receive more immunizations than in the past because now we can protect them from more serious diseases than ever before. Most vaccines used for routine childhood immunizations can be given safely at the same time.

## **Your child needs the following immunizations to stay healthy:**

**Hepatitis B vaccine.** This protects against a virus that may cause serious liver disease, as well as cancer.

Your child needs to receive doses of hepatitis B vaccine at

- Birth
- 1 month of age
- 6 to 18 months of age

Any older child or teen who has not received this vaccine can begin the series of immunizations at any time.

**DTaP vaccine.** This protects against diphtheria (a potentially fatal throat and windpipe infection), tetanus (lockjaw), and pertussis (whooping cough).

Most children should receive this vaccine at ages

- 2 months.
- 4 months.
- 6 months.
- 15 to 18 months.
- 4 to 6 years.
- 11 to 16 years, Routine boosters are needed every 10 years after that.

**H. influenzae type b (Hib) vaccine.** This protects against *Haemophilus influenzae* type b. This bacterium is a major cause of spinal meningitis, pneumonia, and other serious infections.

Your child should receive

- Two or three doses of the Hib vaccine between 2 and 6 months of age
- A booster dose at 12 to 15 months of age

Your pediatrician can tell you about different types of the Hib vaccine that are available.

**Inactivated Polio (IPV) vaccine.** This protects against polio, which can cause paralysis or death. This type of polio vaccine is given as a shot and is recommended for almost everyone. Your child should receive doses of polio vaccine at ages

- 2 months
- 4 months
- 6 to 18 months
- 4 to 6 years

Under certain circumstances your pediatrician may recommend that your child receive the oral polio vaccine, which is given by mouth.

### **Pneumococcal Conjugate vaccine**

This protects against the pneumococcal bacteria, which can cause meningitis, pneumonia, and serious infections in the brain, bloodstream, and ears.

Your child needs this vaccine at ages

- 2 months
- 4 months
- 6 months
- 12 to 15 months

Some children between the ages of 2 and 5 years also may need this vaccine.

### **Measles, Mumps, Rubella (MMR) vaccine**

This protects against measles, mumps, and rubella (German measles).

Your child needs to receive doses of the MMR vaccine at ages

- 12 to 15 months
- 4 to 6 years

Children who do not get the second dose on schedule should receive it at the earliest opportunity.

### **Varicella vaccine**

This protects against chickenpox, which can cause serious complications such as bacterial skin infections, pneumonia, and infections of the brain.

If your child has not had chickenpox, he should receive

- A single dose of the varicella vaccine between the ages of 12 and 18 months
- A single dose at the earliest opportunity if he is an older child (but younger than 13 years) and has not been immunized
- Two doses of the vaccine at least 4 weeks apart, if he is older than 13 years of age and has never been immunized

### **Hepatitis A vaccine**

This protects against a virus that causes liver disease. Hepatitis A virus can be spread from person to person or through contaminated food or water. Hepatitis A vaccine may be given to children in 2 doses 6 months apart to children 1 year of age and older.

## **Make sure your child is protected**

It is important to keep track of your child's immunizations and make sure that your child receives each vaccine on time. Children who lag behind on getting their shots are at risk of getting very sick. They also may spread serious diseases to other people.

Keep a chart that shows each immunization that your child has received. Put that chart in a safe place where you can refer to it. Records can always be obtained from our office if desired.

Vaccine doses that are not given at the recommended age should be given as a 'catch-up' immunization at a later time. Ask your pediatrician if your child's immunizations are up-to-date.

There are some groups of people who should not receive certain vaccines. Those groups may include people with certain allergies or weakened immune systems. Your pediatrician can tell you which vaccines your child should have.

Immunizations are one of the most important ways you can protect your child against serious diseases. Much information is available about immunizations. Your pediatrician can tell you the facts.

Talk with your pediatrician about the vaccines your child needs to stay healthy.

## **Immunizations are safe and effective**

Reactions to vaccines may occur, but they are usually mild. Severe reactions to vaccines are very rare. Children are much more likely to be harmed by serious diseases than by immunizations. Your pediatrician may recommend acetaminophen for common side effects such as irritability and fever. If you have questions about possible reactions, call your pediatrician

## **Immunization Schedule Followed in Our Office**

Birth	Hepatitis B
1 Month	Hepatitis B
2 Months	DTaP, HiB, Polio, and Prevnar
4 Months	DTaP, HiB, Polio, and Prevnar
6 Months	DTaP, HiB, Polio, and Prevnar
9 Months	Hepatitis B
12 Months	Varivax, MMR, Hepatitis A, and Prevnar,
15 Months	DTaP, and HiB
18 Months	Hepatitis A
Yearly	Influenza

# THE NORMAL NEWBORN'S APPEARANCE

Even after your child's physician assures you that your baby is normal, you may find that he or she looks a bit odd. Your baby does not have the perfect body you have seen in baby books. Be patient. Most newborns have some peculiar characteristics. Fortunately they are temporary. Your baby will begin to look normal by 1 to 2 weeks of age.

This discussion of these transient newborn characteristics is arranged by parts of the body. A few minor congenital defects that are harmless but permanent are also included. Call your physician if you have questions about your baby's appearance that this list does not address.

## Head

- 1. Molding.** Molding refers to the long, narrow, cone-shaped head that results from passage through a tight birth canal. This compression of the head can temporarily hide the fontanel. The head returns to a normal shape in a few days.
- 2. Caput.** This refers to swelling on top of the head or throughout the scalp due to fluid squeezed into the scalp during the birth process. Caput is present at birth and clears in a few days.
- 3. Cephalohematoma.** This is a collection of blood on the outer surface of the skull. It is due to friction between the infant's skull and the mother's pelvic bones during the birth process. The lump is usually confined to one side of the head. It first appears on the second day of life and may grow larger for up to 5 days. It doesn't resolve completely until the baby is 2 or 3 months of age.
- 4. Anterior fontanel.** The "soft spot" is found in the top front part of the skull. It is diamond-shaped and covered by a thick fibrous layer. Touching this area is quite safe. The purpose of the soft spot is to allow rapid growth of the brain. The spot will normally pulsate with each beat of the heart. It normally closes with bone between 12 and 18 months of age.

## Eyes

- 1. Swollen eyelids.** The eyes may be puffy because of pressure on the face during delivery. They may also be puffy and reddened if silver nitrate eyedrops are used. This irritation should clear in 3 days.
- 2. Subconjunctival hemorrhage.** A flame-shaped hemorrhage on the white of the eye (sclera) is not uncommon. It's harmless and due to birth trauma. The blood is reabsorbed in 2 to 3 weeks.
- 3. Iris color.** The iris is usually blue, green, gray, or brown, or variations of these colors. The permanent color of the iris is often uncertain until your baby reaches 6 months of age. White babies are usually born with blue-gray eyes. Black babies are usually born with brown-gray eyes. Children who will have dark irises often change eye color by 2 months of age; children who will have light-colored irises usually change by 5 or 6 months of age.

## Ears

- 1. Folded over.** The ears of newborns are commonly soft and floppy. Sometimes one of the edges is folded over. The outer ear will assume normal shape as the cartilage hardens over the first few weeks.
- 2. Earpits.** About 1% of normal children have a small pit or dimple in front of the outer ear. This minor congenital defect is not important unless it becomes infected.

## Nose

The nose can become misshapen during the birth process. It may be flattened or pushed to one side. It will look normal by 1 week of age.

## Mouth

- 1. Sucking callus (or blister).** A sucking callus occurs in the center of the upper lip from constant friction at this point during bottle- or breast-feeding. It will disappear when your child begins cup feedings. A sucking callus on the thumb or wrist may also develop.
- 2. Tongue-tie.** The normal tongue in newborns has a short tight band that connects it to the floor of the mouth. This band normally stretches with time, movement, and growth. Babies with symptoms from tongue-tie are rare.
- 3. Epithelial pearls.** Little cysts (containing clear fluid) or shallow white ulcers can occur along the gumline or on the roof of the mouth. These are a result of blockage of normal mucous glands. They disappear after 1 to 2 months.
- 4. Teeth.** The presence of a tooth at birth is rare. Approximately 10% are extra teeth without a root structure. The other 90% are prematurely erupted normal teeth. The distinction can be made with an x-ray. A dentist must remove the extra teeth. The normal teeth need to be removed only if they become loose (with a danger of choking) or if they cause sores on your baby's tongue.

## Breast

Swollen breasts are present during the first week of life in many female and male babies. They are caused by the passage of female hormones across the mother's placenta. Breasts are generally swollen for 2 to 4 weeks, but they may stay swollen longer in breast-fed and female babies. One breast may lose its swelling before the other one by a month or more. Never squeeze the breast because this can cause infection. Be sure to call your physician if a swollen breast develops any redness, streaking, or tenderness.

## Genitals - Girls

- 1. Swollen labia.** The labia minora can be quite swollen in newborn girls because of the passage of female hormones across the placenta. The swelling will resolve in 2 to 4 weeks.
- 2. Hymenal tags.** The hymen can also be swollen due to maternal estrogen and have smooth 1/2-inch projections of pink tissue. These normal tags occur in 10% of newborn girls and slowly shrink over 2 to 4 weeks.
- 3. Vaginal discharge.** As the maternal hormones decline in the baby's blood, a clear or white discharge can flow from the vagina during the latter part of the first week of life. Occasionally the discharge will become pink or blood-tinged (false menstruation). This normal discharge should not last more than 2 to 3 days.

## Genitals - Boys

- 1. Hydrocele.** The newborn scrotum can be filled with clear fluid. The fluid is squeezed into the scrotum during the birth process. This painless collection of clear fluid is called a "hydrocele." It is common in newborn males. A hydrocele may take 6 to 12 months to clear completely. It is harmless but can be rechecked during regular visits. If the swelling frequently changes size, a hernia may also be present and you should call your physician during office hours for an appointment.
- 2. Undescended testicle.** The testicle is not in the scrotum in about 4% of full-term newborn boys. Many of these testicles gradually descend into the normal position during the following months. In 1-year-old boys only 0.7% of all testicles are undescended; these need to be brought down surgically.
- 3. Tight foreskin.** Most uncircumcised infant boys have a tight foreskin that doesn't allow you to see the head of the penis. This is normal and the foreskin should not be retracted.
- 4. Erections.** Erections occur commonly in a newborn boy, as they do at all ages. A full bladder usually triggers them. Erections demonstrate that the nerves to the penis are normal.

## Bones and Joints

- 1. Tight hips.** Your child's physician will test how far your child's legs can be spread apart to be certain the hips are not too tight. Upper legs bent outward until they are horizontal is called "90 degrees of spread." (Less than 50% of normal newborn hips permit this much spreading.) As long as the upper legs can be bent outward to 60 degrees and are the same on each side, they are fine. The most common cause of a tight hip is a dislocation.
- 2. Tibial torsion.** The lower legs (tibia) normally curve in because of the cross-legged posture your baby was confined to while in the womb. If you stand your baby up, you will also notice that the legs are bowed. Both of these curves are normal and will straighten out after your child has been walking for 6 to 12 months.

- 3. Feet turned up, in, or out.** Feet may be turned in any direction inside the cramped quarters of the womb. As long as your child's feet are flexible and can be easily moved to a normal position, they are normal. The direction of the feet will become more normal between 6 and 12 months of age.
- 4. Long second toe.** The second toe is longer than the great toe as a result of heredity in some ethnic groups that originated along the Mediterranean, especially Egyptians.
- 5. "Ingrown" toenails.** Many newborns have soft nails that easily bend and curve. However, they are not truly ingrown because they don't curve into the flesh.

## Hair

- 1. Scalp hair.** Most hair at birth is dark. This hair is temporary and begins to shed by 1 month of age. Some babies lose it gradually while the permanent hair is coming in; others lose it rapidly and temporarily become bald. The permanent hair will appear by 6 months. It may be an entirely different color from the newborn hair.
- 2. Body hair (lanugo).** Lanugo is the fine downy hair that is sometimes present on the back and shoulders. It is more common in premature infants. It is rubbed off with normal friction by 2 to 4 weeks of age.

## Skin

After the first bath your newborn will normally have a ruddy complexion due to the extra high count of red blood cells. He can quickly change to a pale- or mottled-blue color if he becomes cold, so keep him warm. During the second week of life, your baby's skin will normally become dry and flaky. Many babies also get rashes or have birthmarks. No baby has perfect skin. The babies in advertisements wear makeup.

- 1. Acne of newborn.** More than 30% of newborns develop acne of the face: mainly small, red bumps. This neonatal acne begins at 3 to 4 weeks of age and lasts until 4 to 6 months of age. The cause appears to be the transfer of maternal androgens (hormones) just prior to birth. Since it is temporary, no treatment is necessary. Baby oil or ointments will just make it worse.
- 2. Drooling rash.** Most babies have a rash on the chin or cheeks that comes and goes. Often, this rash is caused by contact with food and acid that have been spit up from the stomach. Rinse your baby's face with water after all feedings or spitting up.

Other temporary rashes on the face are heat rashes in areas held against the mother's skin during nursing (especially in the summertime). Change your baby's position more frequently and put a cool washcloth on the area that has a rash.

**3. Erythema toxicum.** More than 50% of babies get a rash called erythema toxicum on the second or third day of life. The rash is composed of 1/2- to 1-inch-size red blotches with a small white lump in the center. They look like insect bites. They can be numerous, keep occurring, and be anywhere on the body surface (except palms and soles). The cause of this rash is unknown and it is harmless. The rash usually disappears by the time an infant is 2 weeks old, but sometimes not until a child is 4 weeks old.

**4. Forceps or birth canal trauma.** If your baby's delivery was difficult, a forceps may have been used to help him through the birth canal. The pressure of the forceps on the skin can leave bruises or scrapes or can even damage fat tissue anywhere on the head or face.

Pressure from the birth canal can damage the skin overlying bony prominences (such as the sides of the skull) even without a forceps delivery. Fetal monitors can also cause scrapes and scabs on the scalp.

You will notice the bruises and scrapes 1 or 2 days after birth. They will disappear in 1 to 2 weeks.

Injury to fat tissue won't be apparent until the fifth or sixth day after birth. A thickened lump of skin with an overlying scab is what you usually see. This may take 3 or 4 weeks to heal. For any breaks in the skin, apply an antibiotic ointment (OTC) until healed. If it becomes tender to the touch or soft in the center or shows other signs of infection, call your physician.

**5. Milia.** Milia are tiny white bumps that occur on the faces of 40% of newborn babies. The nose and cheeks are most often involved, but milia are also seen on the forehead and chin. Although they look like pimples, they are smaller and not infected. They are blocked-off skin pores and will open up and disappear by 1 to 2 months of age. Do not apply ointments or creams to them.

Any true blisters (little bumps containing clear fluid) or pimples (little bumps containing pus) that occur during the first month of life (especially on the scalp) must be examined and diagnosed quickly. If they are caused by the herpesvirus, they must be treated right away. If you suspect blisters or pimples, call your child's physician immediately.

**6. Mongolian spots.** A Mongolian spot is a bluish-gray, flat birthmark that is found in more than 90% of American Indian, Oriental, Hispanic, and black babies. They occur most commonly over the back and buttocks, although they can be present on any part of the body. They vary greatly in size and shape. Most fade away by 2 or 3 years of age, although a trace may persist into adult life.

**7. Stork bites (pink birthmarks).** Flat pink birthmarks (also called capillary hemangiomas) occur over the bridge of the nose, the eyelids, or the back of the neck in more than 50% of newborns. Most of these spots fade and disappear, but some can persist into adult life. Those on the forehead that run from the bridge of the nose up to the hairline usually persist into adult life. Laser treatment during infancy should be considered.

# COMMON NEWBORN CONCERNS

## Signs of Illness

It is important to be familiar with a few warning signs of severe illness. Just because your child has one or more of these signs doesn't necessarily mean a severe illness is present. If you note any of the following danger signs call your physician:

- Lethargy and listlessness (i.e., lying around, sleeping much more than usual, with or without fever, limp like a rag doll and difficult to wake).
- Vomiting repeatedly (not just spitting up), especially if the vomitus is green. Projectile (very forceful) vomiting.
- Refusal to eat several times in a row.
- Labored, distressed, or rapid breathing.
- Changes of color—especially blueness of the lips and fingernails, or yellow discoloration of the skin or eyes.
- Extreme irritability.
- Rectal temperature of 100° F or higher or any fever in the first 2 months of life.
- Diarrhea, especially if there's mucus, blood or an unusually bad smell
- Hard prolonged crying with no obvious cause
- Inability to see or hear normally
- Unusual rash

## Fever

If your child has a fever, it is probably a sign that her body is fighting an infection. When your child becomes ill because of a virus or bacteria, her body may respond by increasing body temperature. It is important to remember that, except in the case of heat stroke, fever itself is not an illness—only a symptom of one. Fever itself also is not a sign that your child needs an antibiotic.

Many conditions, such as an ear infection, a common cold, the flu, a urinary tract infection, or pneumonia, may cause a child to develop a fever. In some cases, medication, injury, poison, or an extreme level of overactivity may produce a fever. An environment that is too hot may result in heat stroke, a potentially dangerous rise in body temperature. It is important to look for the cause of the fever.

Fevers are generally harmless and help your child fight infection. They can be considered a good sign that your child's immune system is working and the body is trying to rid itself of the infection.

The main purpose for treating fever is to help your child feel better. Reducing her temperature may make her more comfortable until the illness that has caused the fever has been treated or, more likely, run its course.

## **What is a fever?**

A fever is a body temperature that is higher than normal. Your child's normal body temperature varies with his age, general health, activity level, the time of day, and how much clothing he is wearing. Everyone's temperature tends to be lower early in the morning and higher between late afternoon and early evening. Body temperature also will be slightly higher with strenuous exercise.

Most pediatricians consider any thermometer reading above **100°F** a sign of a fever in a newborn. This number may vary depending on the method used for taking your child's temperature. If you call your pediatrician, say which method you used.

## **Signs and symptoms of a fever**

If your child has a fever, her heart and breathing rates naturally will speed up. You may notice that your child feels warm. She may appear flushed or perspire more than usual. Her body also will require more fluids.

Some children feel fine when they have a fever. However, most will have symptoms of the illness that is causing the fever. Your child may have an earache, a sore throat, a rash, or a stomachache. These signs can provide important clues as to the cause of your child's fever.

### **Call Your Child's Physician Immediately If:**

- Looks very ill, is unusually drowsy, or is very fussy
- Has been in an extremely hot place, such as an overheated car
- Has additional symptoms such as a stiff neck, severe headache, severe sore throat, severe ear pain, an unexplained rash, or repeated vomiting or diarrhea
- Has a condition that suppresses immune responses, such as sickle-cell disease or cancer, or is taking steroids
- Has had a seizure
- Is younger than 2 months of age and has a rectal temperature of more than **100°F**

### **Also Call If The Fever Persists For**

- More than 24 hours in a child younger than 2 years of age
- More than 3 days in a child 2 years of age or older

## **How to take 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 if he has a fever and how high the temperature is. There are several types of thermometers and methods for taking your child's temperature.

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 to this toxin.

If your child is younger than 3 years of age, taking his temperature with a rectal digital thermometer provides the best reading.

- Clean the end of the thermometer with rubbing alcohol or soap and water. Rinse it with cool water. Do not rinse 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.
- With the other hand, turn on the thermometer switch and insert the thermometer 0.5” to 1” into the anal opening. Hold the thermometer in place loosely with 2 fingers, keeping your hand cupped around your child’s bottom. Do not insert the thermometer too far. Hold in place for about 1 minute, until you hear the beep. Remove the thermometer to check the digital reading.

## Jaundice

You may have been told that your child has ‘jaundice’ and you probably have many questions about this condition. Jaundice is a common condition in newborn infants that usually shows up shortly after birth. In most cases, it goes away on its own. If not, it can be treated easily.

**What is jaundice?** A baby has jaundice when bilirubin, which is produced naturally by the body, builds up faster than a newborn’s liver can break it down and get rid of it in the baby’s stool. This happens because of one or more of the following reasons;

- The baby’s developing liver is not yet able to remove the bilirubin from the blood
- More bilirubin is being made than the liver can handle
- Too much of the bilirubin is reabsorbed from the intestines before the baby gets rid of it in the stool

Too much bilirubin makes a jaundiced baby’s skin look yellow. This yellow color will appear first on the face, then on the chest and stomach, and, finally, on the legs.

**What is bilirubin?** Everyone’s blood contains hemoglobin found in red blood cells. Red blood cells live only a short time and, as they die, the oxygen-carrying substance (hemoglobin) is changed to yellow bilirubin. Normal newborns have more bilirubin because their liver is not efficient at removing it. Older babies, children, and adults get rid of this yellow blood product quickly, usually through bowel movements.

**Can jaundice hurt my baby?** Jaundice can be dangerous if the bilirubin reaches too high a level in the blood. The level at which it becomes dangerous will vary based on a child’s age and if there are other medical conditions. A small sample of your baby’s blood can be tested to measure the bilirubin level. Other tests may be needed to see if your baby has a special reason to make extra bilirubin that is causing the jaundice.

**How do I know if my baby has jaundice?** Parents should be aware of any changes in their newborn’s skin color or the coloring in the whites of their child’s eyes. Look at the baby under natural daylight or in a room that has fluorescent lights. A quick and easy way to test for jaundice is to press gently with your fingertip on the tip of your child’s nose or forehead. If the skin looks white (this is true for babies of all races), there is no jaundice. If you see a yellowish color, contact your pediatrician to check your baby to see if significant jaundice is present.

**How is jaundice treated?** Mild to moderate levels of jaundice do not require any treatment. If high levels of jaundice do not clear up on their own, your baby may be treated with special lights or other treatments. These special lights help get rid of the bilirubin by altering it to make it easier for your baby's liver to get rid of it. This treatment may require that your baby stay in the hospital for a few days. Some pediatricians treat babies with these lights at home. If your baby needs light therapy, talk to your pediatrician about how long the treatment lasts and where it will be done.

Another treatment is more frequent feedings of breastmilk or formula to help pass the bilirubin out in the stools. Increasing the amount of water given to a child is not sufficient to pass the bilirubin because it must be passed in the stools. Rarely, babies may require treatment of their blood to remove bilirubin. For example, in a few cases of very high bilirubin levels, a blood exchange is done to give a baby fresh blood and remove the bilirubin. Your pediatrician will give you more details if other treatments are necessary. Once your child's bilirubin level goes down, it is unlikely that it will increase again. However, if your child continues to look yellow after 3 weeks of life, talk to your pediatrician, as other tests may need to be done.

**What effect does breastfeeding have on jaundice?** Most breastfed babies do not have a problem with jaundice that requires interruption of breastfeeding. However, if your baby develops jaundice that lasts a week or more, your pediatrician may ask you to temporarily stop breastfeeding for a day or two. If you must temporarily stop breastfeeding, talk to your pediatrician about pumping your breasts so you can keep producing breast milk and can restart nursing easily.

If your baby has jaundice, do not be alarmed. Remember that jaundice in a healthy newborn is not serious and usually clears up easily. If your baby has a very serious case of jaundice and other medical problems, your pediatrician will talk to you about other treatments.

## Colic

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 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, though they often become worse in the early evening.

Unfortunately, there is no definite explanation for why this happens. Most often, colic means simply that the child is unusually sensitive to stimulation. As she matures, it will decrease, and generally it stops by three months. Sometimes, in breast-feeding babies, colic is a sign of sensitivity to a food in the mother's diet. The discomfort is only rarely caused by sensitivity to milk protein in formula. Colicky behavior may also signal a medical problem, such as a hernia or some type of illness.

Perhaps you'll find it reassuring that there's a time limit to this problem, but that doesn't stop the crying now. It may be that you simply will have to wait it out, but there are also several things that might be worth trying. First, of course, rule out any medical reason for the crying.

### **The five S's**

The five S's are a technique to promote calming behavior in your colicky baby by mimicking the peace of your womb. This is the initial response I recommend to colic.

#### **Swaddling**

Tight swaddling is the cornerstone of calming. Swaddling also helps keep babies from accidentally flipping onto their stomach. Avoid overheating and loose blankets.

#### **Side or stomach position**

All babies should be put to sleep on their back. However, being on the side or stomach is best for calming the baby; it turns on the calming reflex and shuts off the Moro reflex. (The Moro reflex makes a baby's arms shoot out when his own crying startles him.) Lie her on her tummy and gently rub or pat her back.

#### **Shushing**

Loud, harsh, white noise mimics the noise of blood flowing through placental arteries when a fetus is in the womb. The louder a baby cries, the louder the shushing has to be to calm him.

#### **Swinging**

Lying motionless deprives newborns of sensory stimulation. Swinging (rhythmic, jiggly movement) in rapid, tiny movements, like a shiver (two to three times a second), soothes agitated babies. Use slow, broad swinging to keep your baby soothed. Never shake a baby in anger.

#### **Sucking**

Sucking triggers the calming reflex and deepens a baby's level of relaxation.

#### **. . . and one V**

To stop a baby's cycle of crying, you must *meet his level of intensity*. Once the screaming diminishes for a few moments, you can gradually lessen the *vigor* of the calming maneuvers.

Other responses to colic you may try.

- If nursing, eliminate milk products, caffeine, onions, cabbage, and any other potentially irritating foods from your diet.
- Walk your baby in a body carrier to soothe her. The motion and body contact will reassure her.
- Run the vacuum in the next room, or place her where she can hear the clothes dryer.
- When you're feeling tense and anxious, have someone else look after the baby—and get out of the house. Even an hour or two away will help you maintain a positive attitude.

# Thrush

## Description

- White, irregularly shaped patches coat the inside of the mouth and sometimes the tongue. (If the only symptom is a uniformly white tongue, it's due to a milk diet, not thrush.)
- The coating adheres to the mouth and cannot be washed away or wiped off.
- Thrush causes mild discomfort.

## Cause

A yeast (called Candida) causes thrush. Most people already have Candida in their mouth and other parts of their bodies. Sometimes certain conditions, such as use of an antibiotic or too much moisture can cause the yeast to grow rapidly and cause thrush. In babies, thrush often occurs in areas where the lining of the mouth is cracking and moist from too much sucking (as when a baby sleeps with a bottle or pacifier). A large pacifier or nipple can also injure the lining of the mouth. Thrush is generally not spread to others under normal conditions. However, if you are breast-feeding and your baby has thrush, the yeast could flare up and cause thrush on your breasts.

## Home Care

- 1. Nystatin oral medicine.** The drug for clearing this up is Nystatin oral suspension. It requires a prescription. Give 1 ml of Nystatin four times a day after meals or at least 30 minutes before you feed your baby. Place the Nystatin in the front of the mouth on each side (it doesn't do any good once it's swallowed). If the patches of thrush in the mouth don't start improving in 2 days, rub the Nystatin directly on the patches. Use a cotton swab or gauze wrapped on your finger. Keep this up for at least 7 days, or until all the thrush has been gone for 3 days. If you are breast-feeding, apply Nystatin to any irritated areas on your nipples. If the nystatin fails other prescription medicines may be tried.
- 2. Decrease sucking time during feeding,** If sucking on a nipple is painful for your child, temporarily use a cup and spoon. In any case, while your child has thrush, reduce sucking time to 20 minutes or less per feeding. If the thrush comes back after treatment and your child is bottle-fed, switch to a nipple with a different shape and made from silicone.
- 3. Restrict pacifier use to bedtime.** While your child has thrush don't give him a pacifier, except when it's really needed for going to sleep. If your infant is using an orthodontic-type pacifier, switch to a smaller, regular one. Soak all nipples in water at 130 degrees F (60 degrees C), which is the temperature of most hot tap water, for 15 minutes.
- 4. Diaper rash associated with thrush.** If your child has a diaper rash as well as thrush, assume the rash is caused by yeast. Ask for a prescription for Nystatin cream and put it on your baby's bottom four times a day.

## Call Your Child's Physician During Office Hours If:

- Your child refuses to drink.
- The thrush gets worse during treatment.
- The thrush lasts beyond 10 days.
- You have other concerns or questions.

# Spitting Up by Infants (GE Reflux)

## Description

Spitting up (also called regurgitation) is the effortless spitting up of one or two mouthfuls of stomach contents. Formula or breast milk just rolls out of the mouth, often with a burp. It usually happens during or shortly after feedings. It begins in the first weeks of life.

Spitting up is harmless as long as your infant doesn't spit up large amounts that interfere with normal weight gain.

This condition is also called gastroesophageal reflux (GE reflux).

## Cause

Spitting up results from poor closure of the valve (ring of muscle) at the upper end of the stomach. Spitting up is normal and harmless for over half of all babies. It becomes a problem if it causes poor weight gain (from spitting up large amounts), choking, or acid damage to the lower esophagus (esophagitis).

## Expected Course

Spitting up improves with age. By 7 months of age, most reflux has decreased or is gone. The reasons for this are probably because the baby is old enough to sit up or is eating solid foods. By the time your baby has been walking for 3 months, even severe reflux should be totally cleared up.

## Home Care

- 1. Feed smaller amounts.** Overfeeding always makes spilling up worse. If the stomach is filled to capacity, spitting up is more likely. Give your baby smaller amounts (at least 1 ounce less than you have been giving). Your baby doesn't have to finish a bottle. Wait at least 2 and 1/2 hours between feedings because it takes that long for the stomach to empty itself.
- 2. Avoid pressure on your child's abdomen.** Avoid tight diapers. They put added pressure on the stomach. Don't double your child up during diaper changes. Don't let people hug your child or play vigorously with him right after meals.
- 3. Burp your child to reduce spitting up.** Burp your baby two or three times during each feeding. Do it when he pauses and looks around. Don't interrupt his feeding rhythm in order to burp him. Keep in mind that burping is less important than giving smaller feedings and avoiding tight diapers.
- 4. Keep your child in a vertical position after meals.** After meals, try to keep your baby in an upright position using a frontpack, backpack, or swing for 30 minutes. When your infant is in an infant seat, keep him from getting scrunched up by putting a pad under his buttocks so he's more stretched out. After your child is over 6 months old, a jumpy seat or infant play table can be helpful for maintaining an upright posture after meals.

- 5. Use a proper sleep position.** Most infants with spitting up problems can sleep on their backs, the position recommended by the American Academy of Pediatrics to reduce the risk of SIDS. Another option for severe reflux is sleeping on the right side. If the esophagus becomes irritated (esophagitis), talk to your doctor about sleeping prone (facedown). Try to elevate the head of the bed a bit.
- 6. Add rice cereal to formula.** If your infant still spits up large amounts after all the previous treatments have been tried, you can try thickening the formula with rice cereal. Add 1 level teaspoon of rice cereal to each ounce of formula. You also need to make the nipple opening bigger.
- 7. Acid blockers or liquid antacids.** Children with severe reflux or symptoms of heartburn need temporary reduction of stomach acid. Ask your physician first.

**Call Your Child's Physician Immediately If:**

- You see blood in the spit-up material.
- The spitting up causes your child to choke or cough.

**Call Your Child's Physician During Office Hours If:**

- Your baby doesn't seem to improve with this approach.
- Your baby does not gain weight normally.
- You have other concerns or questions.

## **Diaper Rash**

**What is diaper rash?** Diaper rash can be any rash that develops inside the diaper area. In mild cases, the skin might be red. In more severe cases, there may be painful open sores. You will usually see a rash around the abdomen, genitalia, and inside the skin folds of the thighs and buttocks. Mild cases clear up within 3 to 4 days without any treatment. If a rash persists or develops again after treatment, consult your pediatrician.

**What causes diaper rash?** Over the years diaper rash has been blamed on various causes, such as teething, diet, and ammonia in the urine. However, medical experts now believe it is caused by any of the following:

- Too much moisture
- Chafing or rubbing
- Prolonged contact of the skin with urine, feces, or both
- Yeast infection
- Bacterial infection
- Allergic reaction to diaper material

When skin stays wet for too long, the layers that protect it start to break down. When wet skin is rubbed, it also damages more easily. Moisture from a soiled diaper can harm your baby's skin and make it more prone to chafing. When this happens, a diaper rash may develop.

Further rubbing between the moist folds of the skin only makes the rash worse. This is why diaper rash often forms in the skin folds of the groin and upper thighs.

More than half of babies between 4 months and 15 months of age develop diaper rash at least once in a 2-month period. Diaper rash occurs more often in the following instances:

- If babies are not kept clean and dry
- In babies who have frequent stools, especially when the stools stay in their diapers overnight
- When babies begin to eat solid foods especially fruit
- When babies are taking antibiotics, or in nursing babies whose mothers are taking antibiotics

Infants taking antibiotics are more likely to get diaper rashes caused by yeast infections. Yeast infects the weakened skin and causes a bright red rash with red spots at its edges. You can treat this with over-the-counter antifungal medications, If you see these symptoms, you may wish to consult with your pediatrician.

**What can I do to prevent diaper rash?** To help prevent diaper rash from developing, you should:

- Change the diaper promptly after your child wets or has a bowel movement. This limits moisture on the skin.
- Do not put the diaper on airtight, especially overnight. Keep the diaper loose so that the wet and soiled parts do not rub against the skin as much.
- Gently clean the diaper area with water. You do not need to use soap with every diaper change or after every bowel movement. (Breast-fed infants may stool as many as 8 times a day.) Use soap only when the stool does not come off easily.
- Do not use talcum or baby powder because they could cause breathing problems in your infant.
- Avoid over-cleansing with wipes that can dry out the skin. The alcohol or perfume in these products may irritate some babies' skin.

**What can I do if my baby gets diaper rash?** If diaper rash develops despite your best efforts to prevent it, try the following:

- Change wet or soiled diapers often.
- Use clear water to cleanse the diaper area with each diaper change.
- Pat dry; do not rub. Allow the area to air dry fully.
- Apply a thick layer of protective ointment or cream (such as one that contains zinc oxide or petrolatum) to form a protective coating on the skin. These ointments are usually thick and pasty and do not have to be completely removed at the next diaper change. Remember that heavy scrubbing or rubbing will only damage the skin more.

**Call Your Child's Physician During Office Hours If The Rash:**

- Has blisters or pus-filled sores
- Does not go away within 48 to 72 hours

**Which type of diaper should I use?** There are many different brands of diapers. Diapers are made of cloth or disposable materials. After they get soiled, you can wash cloth diapers and use them again and you throw away disposable diapers.

Research suggests that diaper rash is less common with the use of disposable diapers. In childcare settings, children who wear super-absorbent disposable diapers tend to have lower rates of diaper rash. Regardless of which type of diaper you use, diaper rash occurs less often and is less severe when you change diapers often. If you use a cloth diaper, you can use a stay-dry liner inside it to keep your baby drier.

If you choose not to wash cloth diapers yourself; you can have a diaper service clean them. If you do your own washing, you will need to presoak heavily soiled diapers. Keep and wash soiled diapers separate from other clothes. Use hot water and double-rinse each wash. Do not use fabric softeners or antistatic products on the diapers because they may cause rashes in young, sensitive skin.

Whether you use cloth diapers, disposables, or both, always change diapers as needed to keep your baby clean, dry, and healthy.

**Remember—never leave your baby alone on the changing table or on any other surface above the floor. Even a newborn can make a sudden turn and fall to the floor.**

Diaper rash is usually not serious, but it can cause your child discomfort. Follow the steps listed above to help prevent and treat diaper rash.

## **Eczema (Atopic Dermatitis)**

### **Description**

- red, extremely itchy rash
- often starts on the cheeks at 2 to 6 months of age
- most common on flexor surfaces (creases) of elbows, wrists, and knees
- occasionally on neck, ankles, and feet if scratched, rash becomes raw and weepy
- constantly dry skin.

### **Cause**

Eczema is an inherited type of sensitive, dry skin. A personal history of asthma or hay fever or a family history of eczema makes it more likely that your child has eczema. Flare-ups occur when there is contact with irritating substances (for example, soap or chlorine).

In 30% of infants with eczema, certain foods cause the eczema to flare up. If you suspect a particular food item (for example, cow's milk, eggs, or peanut butter) is causing your child's flare-ups, feed that food to your child one time (a "challenge") after avoiding it for 2 weeks. If the food is causing flare-ups, the eczema should become itchy or develop hives within 2 hours of eating the food. If this occurs, avoid ever giving this food to your child and talk to your physician about food substitutes.

## Expected Course

This is a chronic condition and will usually not go away before adolescence. The goal is control, not cure. The early treatment of any itching can help prevent a severe rash.

## Home Treatment

- 1. Steroid creams.** Steroid creams are the main treatment of the itch of eczema. Apply this cream to any spot that itches. Also use it for mild flare-ups. After the rash quiets down, use it for an additional week. When you travel with your child, always take the steroid cream with you. If it starts to run out, buy some more or get the prescription refilled.
- 2. Hydrating the skin.** Hydration of the skin followed by lubricating cream is the main way to prevent flare-ups of eczema. Your child should have one bath a day for 10 minutes. Water-soaked skin is far less itchy. Eczema is very sensitive to soap especially bubble bath. Young children can usually be cleaned without any soap. Teenagers need a soap to wash under the arms, the genital area, and the feet. They can use a nondrying soap such as Dove for these areas. Keep shampoo off the eczema.
- 3. Lubricating cream.** Apply a lubricating cream once daily (twice a day during the winter) every day. Some lubricating creams are Keri, Lubriderm, Nivea, and Nutraderm. Children with eczema always have dry skin. After a 10-minute bath, the skin is hydrated and feels good. Help trap the moisture in the skin by applying an outer layer of lubricating cream to the entire skin surface while it is damp (within 3 minutes of leaving the bath). Apply it after you have put steroid cream on any itchy areas. Avoid applying any ointments, petroleum jelly, or vegetable shortening because they can block the sweat glands, increase the itching, and worsen the rash (especially in warm weather). Also, soap is needed to wash them off. For severe eczema, ointments may be needed temporarily to heal the skin.
- 4. Itching.** At the first sign of any itching, apply the steroid cream to the area that itches. Keep your child's fingernails cut short. Also, wash your child's hands with water frequently to avoid infecting the eczema.
- 5. Antihistamine Medicine.** An antihistamine is needed at bedtime for itching that is keeping your child from getting to sleep or causes your child to wake up during the night.

## Prevention

Wool fibers and clothes made of other scratchy, rough materials make eczema worse. Cotton clothes should be worn as much as possible. Avoid triggers that cause eczema to flare up, such as excessive heat, sweating, excessive cold, dry air (use a humidifier), chlorine, harsh chemicals, and soaps. Never use bubble bath. Also, keep your child off the grass during grass pollen season (May and June). Keep your child away from anyone with fever blisters since the herpesvirus can cause a serious skin infection in children with eczema.

Try to breast-feed all high-risk infants. Otherwise, use a soy formula. Also try to avoid cow's milk products, soy, eggs, peanut butter, wheat, and fish during your infant's first year.

### Call Your Child's Physician Immediately If:

- The rash looks infected and your child has a fever.
- The rash flares up after contact with fever blisters.

**Call Your Child's Physician During Office Hours If:**

- The rash becomes raw and open in several places.
- The rash looks infected (red streaks, pus, and yellow scabs).
- The rash hasn't greatly improved in 7 days of treatment.
- You have other concerns or questions.

## Cradle Cap

**Description**

Cradle cap consists of oily, yellow scales on the scalp. It begins in the first weeks of life and is probably caused by adult hormones that crossed the placenta before birth. Without treatment it can last for months; with treatment it usually is cleared up in a few weeks.

**Home Treatment**

- 1. Antidandruff shampoo.** Buy an antidandruff shampoo (nonprescription) at the drugstore. Wash your baby's hair with it once a day. While the hair is lathered, massage your baby's scalp with a soft brush or rough washcloth. Don't worry about hurting the soft spot. Once the cradle cap has cleared up, use a regular shampoo twice a week.
- 2. Softening thick crusts.** If your child's scalp is very crusty, put some baby oil or olive oil on the scalp 1 hour before washing to soften the crust. Wash all the oil off however, or it may worsen the cradle cap.
- 3. Resistant cases of cradle cap.** If the rash is very red and irritated, apply 1% hydrocortisone cream (nonprescription) three times a day for 7 days.

**Call Your Child's Physician Immediately If:**

- The cradle cap lasts more than 2 weeks with treatment.
- The rash spreads beyond the scalp.
- You have other concerns or questions.

## Blocked Tear Duct

**Description**

- The eye is always watery.
- Tears run down the face even without crying.
- During crying, the nostril on the blocked side remains dry.
- Symptoms begin before a child is 1 month old.
- The eye is not red and the eyelid is not swollen (unless the soggy tissues become infected).

**Cause**

Your child probably has a blocked tear duct on that side. This means that the channel that normally carries tears from the eye to the nose is blocked. Although the obstruction is present at birth, the occasional delay in tear production until the age of 3 or 4 weeks in some babies can explain the delay in onset of symptoms.

## **Expected Course**

This is a common condition, affecting 6% of newborns. Both sides are blocked 30% of the time. Over 90% of blocked tear ducts open up spontaneously by the time a child is 1 year old. If the blockage continues after age 1 year, an ophthalmologist (eye specialist) can open it with a probe.

## **Home Treatment**

Massage the lacrimal sac (where tears collect) twice a day to empty it of old fluids. Always wash your hands carefully before doing this. The lacrimal sac is in the inner, lower corner of the eye. Start at the inner corner of the eye and gently press upward, using a cotton swab. A small amount of clear fluid should come out. Massaging must be done gently, since it may irritate the eyelid tissue and contribute to infection.

Because of poor drainage, eyes with blocked tear ducts become easily infected. The infected eye produces a yellow discharge. If the eye becomes infected, it is very important to begin antibiotic eyedrops and to stop the massage.

### **Call Your Child's Physician Immediately If:**

- The eyelid becomes very red or swollen.
- A red lump appears at the inner lower corner of the eyelid.

### **Call Your Child's Physician During Office Hours If:**

- Lots of yellow discharge occurs.
- The eye is still watering after your child is 1 year old.
- You have other concerns or questions.

## **Umbilical Cord Infection**

### **Bleeding**

A few drops of blood at the point of separation of the cord is common. The area may bleed a few times from the friction of the diaper or your baby's normal movements.

The bleeding usually stops by itself or can be stopped easily by direct pressure with sterile gauze.

### **Oozing**

The umbilicus (navel) is oozing or moist or may even have some dried pus on the surface. Sometimes the cord has already fallen off, but more often it is still attached. Your baby probably has a mild infection of the navel from surface bacteria. It usually can be cleared up fairly quickly. Infection of the umbilicus must be treated with respect because of the risk of spread to the liver or the abdominal cavity.

Do not put talcum powder on the umbilicus; it can cause irritation and tissue reaction. Ointments should be avoided, because they delay drying and healing.

## Delayed Separation

Although most umbilical cords fall off between 10 and 14 days of age, an occasional cord may stay for 3 weeks or longer. Cords can also hang on by a strand of tissue for 2 or 3 days. Sometimes a scar known as a granuloma can hold on the cord. Delayed separation is not a medical problem. Eventually they all fall off so just be patient about it.

### Call Your Child's Physician Immediately If:

- Bleeding doesn't stop after 10 minutes of direct pressure.
- Any bleeding amounts to more than the size of a quarter.
- Red streaks develop on the normal skin surrounding the navel.
- Pimples or blisters appear around the navel.
- Your baby's rectal temperature is over 100.4 degrees F (38.0 degrees C) or under 97.5 degrees F (36.8 degrees C)
- Your baby acts sick.

### Call Your Child's Physician During Office Hours If:

- Bleeding continues for more than 3 days.
- You have other questions or concerns.

# FEEDING YOUR BABY

## Breast Feeding

### The Advantages of Breast-Feeding

Breast-feeding is considered the preferred method of feeding babies because it offers many advantages to both babies and mothers. You should know the benefits of breast-feeding before you make your final decision about how to feed your baby.

### How does my baby benefit from breast-feeding?

- 1. A mother's breast milk is the perfect food for babies.** The only food your baby needs for about 6 months is breast milk. After you start feeding your baby solid foods, you can continue breast-feeding until your child is a year old or even older.

Human milk is nature's perfect design for helping your baby's body and brain grow and develop. No formula can be made exactly the same as human milk because we do not know all the ingredients of human milk.

Babies can digest breast milk easily. A diet of breast milk produces loose bowel movements that a baby can easily pass. Constipation is rare in breast-fed infants.

- 2. Breast-feeding protects your baby from sickness.** Breast-feeding helps protect your baby from illnesses including diarrhea, ear infections, pneumonia, and serious illnesses. Breast-feeding improves your baby's chances of remaining healthy.

**3. Nursing is a valuable source of security and comfort for your baby.** You and your baby give comfort to each other. Your baby regularly needs your breast milk and physical closeness, and your full breasts regularly need to be emptied. Breast-feeding develops an intimate relationship that can deepen the bond between you and your baby.

**4. Breast-fed babies have fewer allergies.** Your baby is less likely to have skin problems and asthma than babies who are fed formula.

### **How do I benefit from breast-feeding?**

**1. Breast-feeding helps your uterus shrink after delivery.** Nursing causes your body to release a hormone called oxytocin. This hormone helps your uterus return to its normal size after delivery.

**2. Breast-feeding is very convenient.** No matter where you are, the perfect food is ready for your baby. It is at the right temperature and in the correct amount. You can take your baby with you anywhere, knowing your milk will be ready for him whenever he is hungry.

**3. You can switch to bottle-feeding if you decide you want to stop breast-feeding, but the opposite may not be true.** If you decide you do not want to nurse anymore, you can stop breast-feeding and switch to bottle-feeding. On the other hand, after starting bottle-feeding, you usually cannot switch to breast-feeding weeks later.

Carefully consider the advantages of breast-feeding for you and your baby and think about giving breast-feeding a try. Remember, the success of breast-feeding is best measured by how much you and your baby enjoy nursing, not only by the amount of milk you produce or the length of time you breast-feed.

### **How Often to Feed**

The baby should nurse for the first time in the delivery room. The second feeding will usually be at 4 to 6 hours of age, after he awakens from a deep sleep. Until your milk supply is well established (usually 4 weeks), nurse your infant whenever he cries or seems hungry (demand feeding). Thereafter, babies can receive enough milk by nursing every 2 to 2-and-1/2 hours. If your baby cries and less than 2 hours have passed, he can be rocked or carried in a frontpack. However, waiting more than 2-and-1/2 hours can lead to swollen breasts (engorgement), which decreases milk production. (Feeding less frequently is OK at night, but no more than 5 hours should pass between feedings.)

Your baby will not gain adequately unless he nurses 8 or more times per day initially. The risks of continuing to nurse at short intervals (more often than every 1 and 1/2 hours) are that “grazing” will become a habit, your baby won’t be able to sleep through the night, and you won’t have much free time.

## How Long Per Feeding

During the first week, bring in your full milk supply by offering both breasts with each feeding. Try 10 minutes on the first breast and as long as your baby wants on the second breast (at least 10 minutes). Alternate which breast you start on. You may need to stimulate your baby to take the second breast.

After your milk supply has come in (by day 8 at the latest), encourage your baby to nurse as long as she wants to on the first breast (up to 20 minutes). This is so your baby can get the high-fat, calorie-rich hind milk. You can tell your baby has finished the first breast when the sucking slows down and your breast becomes soft. Then offer the second breast if your baby is interested. Alternate breasts at the start of each feeding.

## How Do I Know My Baby Is Getting Enough Milk?

You can't see exactly how much milk your baby takes while nursing. However, you can tell whether breast-feeding is off to a good start if you know what to look for. The following patterns are typical of well-nourished, breast-fed babies during the first month of life.

- 1. You start producing milk abundantly 2 to 4 days after your baby is born.** If your baby seems hungry after most nursings or you do not think your milk has come in by 5 days after delivery, tell your baby's doctor and have your baby weighed.
- 2. Your baby latches on to your breast correctly and sucks rhythmically for at least 10 minutes at each breast.** Your baby may pause sometimes while breast-feeding. However, he should nurse vigorously during most of the feeding. You should hear your baby swallow regularly while breast-feeding.

A baby usually gets more milk by nursing at both breasts than by nursing from one side only. If your baby usually falls asleep and will not feed at the second breast, it is best to divide the time the baby does nurse between the two breasts. For example, a sleepy baby usually will obtain more milk by nursing 5 minutes at each breast than 10 minutes at one breast. Start each feeding on a different side so both breasts get the same stimulation and emptying.

- 3. Your newborn nurses at least eight times every 24 hours.** Nurse your baby every 1 and 1/2 to 3 hours, with possibly a single longer stretch (up to 5 hours) between feedings at night. Time the feedings from the beginning of one nursing to the beginning of the next. Very few breast-fed babies gain enough weight if they are nursed every 4 hours (that is, only six times every 24 hours).

Sometimes you may need to awaken your baby to nurse. Some babies just don't demand to feed as often as they should, especially in the first few weeks of life.

- 4. Your baby appears satisfied after nursings and may fall asleep at the second breast.** Breast-fed infants who appear hungry after most feedings -- who cry, chew their hands, or often need a pacifier after nursing -- may not be getting enough milk.

- 5. Your breasts feel full before each feeding and softer after your baby has nursed.** One breast may drip milk while your baby nurses on the other side. After the longest time between feedings at night, your breasts should feel particularly full.
- 6. Your baby's bowel movements look like cottage cheese and mustard by the 4th or 5th day of life.** Bowel movements that look like cottage cheese and mustard are called "milk stools." If your baby is still having dark meconium, green, or brown stools by 5 days of age, you should have your baby weighed to see if he is getting enough milk.
- 7. Your baby urinates 6 or more times a day once your milk has come in.** The urine should be colorless, not yellow. If it looks like the diaper has reddish brick dust on it after your baby is older than 3 days, your baby's urine probably is too concentrated and your baby may not be getting enough milk.
- 8. Your baby has 4 or more good-sized bowel movements each day.** Many breast-fed babies have a bowel movement every time they nurse during their first 3 to 4 weeks of life. If your newborn is having fewer than 4 bowel movements each day, you should have your baby weighed to see if he is getting enough milk.
- 9. Your nipples may be a little tender for the first several days of nursing, especially at the beginning of feedings. The discomfort should be nearly gone by the end of the first week of breast-feeding.** Nipple pain that is severe, lasts throughout a feeding, or continues more than 1 week after birth probably means your baby is nursing incorrectly. If your baby doesn't latch on properly to nurse, your infant may not be getting enough milk. If you do have very sore nipples, ask your infant's doctor to check your baby's weight and to refer you to a breast-feeding specialist who can look at how your baby is nursing.
- 10. Two or three weeks after delivery you may notice the sensations associated with the milk ejection, or milk let-down, reflex.** The sensations of the milk ejection reflex are tingling, pins-and-needles, or tightening feeling in your breasts as milk begins to flow. If you don't notice any signs of milk let-down, your milk supply may be low.
- 11. Once your milk comes in, your breast-fed baby gains about 1 ounce each day for the first couple months of life.** The only way to be absolutely certain that your baby is getting enough milk is to have your baby weighed regularly. If your baby is not gaining enough weight, your milk supply may be low or your baby may not be nursing effectively. Such breast-feeding difficulties are easier to overcome if you recognize and treat them early. Your baby's doctor can help develop a feeding plan tailored for you and your baby or can refer you to a breast-feeding specialist.

## **How to Increase Your Milk Supply**

Your breasts should produce a generous supply of milk if:

- your baby regularly and effectively sucks from your breasts
- your breasts are regularly and effectively emptied during feedings (or by breast pumping).

Typically, the more milk you remove from your breasts, the more milk you will make. If your milk supply is low, there is a good chance you can increase it by stimulating and emptying your breasts more effectively. In general, the longer your milk supply has been low, the longer it will take to produce more milk. In some cases, it may not be possible to increase a very low milk supply to normal levels no matter what you do.

### **What causes a low milk supply?**

Low milk supply is one of the most common breast-feeding problems for nursing mothers.

Frequent causes of a low milk supply include:

- having a non-demanding, sleepy baby who does not awaken often enough to nurse or who does not suck vigorously
- being separated from your baby during the first week after delivery (for example, if your baby was sick and you were not able to nurse or pump)
- having a baby who sucks improperly and doesn't empty your breasts well
- regularly using formula supplement, causing your baby to nurse less frequently
- having a baby who sleeps though the night (7 or more hours) without nursing
- being ill yourself with complications after the delivery, such as high blood pressure, anemia, or an infection
- being under a lot of stress, going on a weight-loss diet, or going back to work
- having very sore nipples that make it hard for you to breast-feed
- having had previous breast surgery, especially if it damaged your milk ducts.

A few women are unable to make sufficient milk even though they are nursing a vigorous, healthy baby and using proper technique. Sometimes no apparent cause can be found for a mother's low milk supply. The popular myth that every woman can breast-feed successfully is simply not true.

### **How do I increase my milk supply?**

**Try to nurse your baby more often.** If your baby is sleepy, undress your baby to wake her up. Try switching breasts every 5 minutes. If your baby is underweight, premature, ill, or has neurologic problems, your doctor may recommend that you limit the length of each breast-feeding so you don't tire the baby. As your baby gets stronger, she can nurse for a longer time. Meanwhile, your baby probably will need extra feedings until your milk supply increases and she gains more weight. You can use either infant formula or breast milk that you have pumped for these extra feedings.

**Drink plenty of fluids, eat well, rest, and get support from friends and family.** Drink plenty of liquids each day and eat regular nutritious meals, plus healthy snacks. Try to get additional rest by doing only the bare necessities for at least 2 weeks. Try not to get discouraged. Keep thinking positively. Get help and support from your close friends and family.

**Pump your breasts.** Use a rented, hospital-grade, electric breast pump--preferably with a double collection system--to pump your breasts after feedings about every 2 to 3 hours. Try to pump right after you nurse your baby. You can go 5 hours without pumping one time at night, but aim for 7 pumpings every 24 hours.

Record the amount of milk you pump each time. The totals for each day will help you know how much your milk supply is increasing.

Using an electric breast pump to stimulate and empty your breasts is especially important if your baby needs extra feedings of infant formula. Babies getting extra feedings may nurse less often, and some who are fed with a bottle will nurse less effectively.

To find where you can rent a pump, call Ameda/Egnell at 1-800-323-4060; Medela, Inc., at 1-800-Tell-You (1-800-835-5968); or White River at 1-800-342-3906.

### **How do I give my baby extra feedings?**

Remember that above all else, your baby's welfare is the most important concern. If your baby is very underweight, the doctor may decide that your infant needs to gain weight fast. In this case the doctor may recommend giving your baby formula or extra breast milk in addition to the breast milk your baby gets from nursing. These extra feedings may be necessary while you work on increasing your milk supply. A seriously underweight infant is not in any condition to stimulate more milk production by long sessions of nursing. Regular use of a hospital-grade electric breast pump after nursings will be more helpful in increasing your milk supply while your baby catches up in his growth. Prompt improvement in your baby's weight will reassure you and your doctor about your baby's health. Your baby will probably nurse better once he reaches a healthy weight.

When extra feedings are necessary, your expressed breast milk or formula can be fed to your baby by bottle, cup, syringe, or a device called a Supplemental Nursing System (SNS). Bottles are usually the fastest way to feed an underweight baby. Once a baby has reached a healthy weight, one of the other, slower methods can be used. You should not try to use one of these other feeding methods unless a lactation consultant or a health care provider shows you how.

## **The Let-Down Reflex (Milk Ejection Reflex)**

### **What is the let-down reflex (milk ejection reflex)?**

When you breast-feed, your baby's suckling stimulates nerves in your nipple. These nerves carry a message to your brain, and the hormone oxytocin is released from your pituitary gland. Oxytocin flows through your bloodstream to your breasts, where it causes tiny muscle cells around your milk glands to squeeze milk out of the glands and into the milk ducts. This is known as the let-down reflex or the milk ejection reflex.

Once your let-down is working well (usually by 2 weeks after delivery), you may feel a pins-and-needles or tingling sensation in your breasts when you nurse or pump. Milk will usually drip from one breast while you are feeding on the other side. Sometimes your let-down will occur just when you hear your baby cry or think about nursing your baby. A well-functioning let-down reflex helps ensure your breasts get emptied and your baby easily obtains milk.

Sometimes a woman's milk ejection reflex doesn't work as well as it should. This can cause breast-feeding difficulties. For example, you may have problems emptying milk from your breasts, or your baby may not get enough milk.

## **What causes a poor let-down reflex?**

Several situations may prevent the milk ejection reflex from working well, such as:

- severely sore nipples that cause you to tense up before each nursing
- stress, anxiety, and tension; for example, trying to pump breast milk during a short break at work
- being separated from your baby; for example, having a premature infant who is unable to nurse, making it necessary for you to use a pump to express breast milk
- previous breast surgery that has damaged the normal nerve pathways to the nipple, such as breast reduction or enlargement surgery. If you have altered sensation in your nipple after surgery (that is, your nipple is either somewhat numb or super-sensitive), it is possible that nerve damage from the procedure could interfere with your milk ejection reflex.

## **How can I trigger the let-down reflex and improve my milk flow?**

The following suggestions can help trigger the let-down reflex and improve milk flow:

- Try to nurse or pump in a place that is familiar, comfortable, and restful.
- Drink a beverage whenever you sit down to nurse or pump.
- Play soft music or do relaxation exercises before you nurse or pump.
- Gently massage your breasts before you nurse or pump.
- Have your partner give you a backrub before you nurse or pump.
- Put a warm washcloth or heating pad on your breasts, or take a warm shower before you nurse or pump.
- If you are pumping because you are separated from your infant put a photograph of your baby by the pump.

## **The Storage and Handling of Breast Milk**

There may be times when you need to be away from your baby and unable to nurse. You may need to return to work before your baby has stopped nursing. The baby's father or another person may want to feed the baby. Or, your baby may not be able to breast-feed for a while because of a medical problem. In all these instances when your baby can't be breast-fed, it is best for your baby to be fed milk that has been pumped from your breasts. Thus, you will want to know how to handle and store your breast milk safely for later use.

### **Preparation and Hygiene**

- Always wash your hands thoroughly before you pump your breasts. A daily shower or bath will keep your breasts clean.
- After each use of a breast pump, wash all the parts that come into contact with your milk. Use hot soapy water.
- Tell your doctor and your baby's doctor if you become ill or need to take any medication.

### **Collection of Milk**

- Pour the milk expressed during one pumping session into a clean plastic container. (Plastic is better than glass because some of the immune factors in breast milk stick to glass.) You may use a plastic bottle that has been washed in soapy water and rinsed, or a disposable bottle bag. If you use disposable bottle bags, put one inside another to prevent tears or holes.

- Tightly cap bottles. Do not store bottles with nipples attached. Bottle bags are best closed with a clean rubber band.
- Label each container with your baby's name and the date and time the milk was expressed. Put several bottle bags in a larger plastic bag to prevent them from sticking to the freezer shelf

### **Storage of Breast Milk**

Milk may be stored:

- In the refrigerator for at least 72 hours after pumping and 24 hours after thawing (assuming the temperature of the refrigerator is 34<sup>0</sup>F to 40<sup>0</sup>F)
- In a freezer inside a refrigerator for up to 3 weeks after pumping (assuming the temperature of the freezer is 20<sup>0</sup>F to 28<sup>0</sup>F)
- In a separate-door freezer for up to 3 months after pumping (assuming the temperature of the freezer is 5<sup>0</sup>F to 15<sup>0</sup>F)
- In a deep freezer for up to 6 months after pumping (assuming the temperature of the freezer is 0 degrees F or below).

### **Thawing of Milk**

Milk may be thawed:

- Slowly in the refrigerator. Volumes of 3 or more ounces (100 or more milliliters) of milk may take several hours to thaw.
- Relatively quickly under running warm water or by placing it in a bowl of warm water. Be sure the top of the container remains above the water at all times. Do not thaw milk at room temperature.

### **Warming of Milk**

You need only to take the chill off cold milk. You do not need to heat it. You may warm chilled milk:

- under warm running water
- in a pan of warm water (not over direct heat) in a purchased bottle warmer.

### **About Microwave Heating**

Authorities recommend AGAINST using a microwave oven to either thaw or heat expressed milk. Milk can overheat very easily in a microwave. Babies have been accidentally burned by milk that was too hot. Furthermore, overheating can destroy many of the immune properties of breast milk.

### **Additional Recommendations**

- DO NOT thaw milk by letting it sit out of the refrigerator or freezer at room temperature.
- DO NOT overheat milk. Overheating will cause it to curdle and will destroy some immune components.
- DO NOT leave milk at room temperature for more than 1 hour.
-

- Milk may be reheated and used for the next feeding if it has not been left at room temperature for more than 1 hour. Throw out any milk left after a second feeding. DO NOT refreeze thawed milk.
- DO NOT store milk in the door of your freezer, where the temperature may change frequently.
- Always transport milk on ice in an insulated cooler.
- For healthy babies who are not in the hospital, it is safe to layer milk collected at different times on the same day in the same bottle. Chill freshly expressed milk in the refrigerator before adding it to previously frozen milk.

## General Recommendations for Breast-Feeding Mothers

In general, nursing mothers produce breast milk of excellent quality. However, the amount of milk each woman produces may vary. Your physical well being, your diet, and how much rest you get can affect your milk supply. But, the most important influences on milk production are how often you feed your baby (or pump your breasts) and how effectively milk is removed from your breasts.

Many women have questions about how they will need to change their lifestyles while nursing. They fear that they may be restricted in many ways. In fact, the vast majority of women can comply with these recommendations for successful breast-feeding:

- 1. Follow the same guidelines for healthy eating recommended to you during your pregnancy.** Eat a variety of foods at regular mealtimes and keep nutritious snacks on hand if you are hungry between meals. Eat more fresh fruits, vegetables, whole-grain breads and cereals, dairy products, and protein-rich meats, fish, poultry, and legumes.
- 2. Drink plenty of liquids each day.** Your body needs extra water to produce breast milk. Pour yourself a glass of water each time you sit down to nurse. If you feel thirsty, make sure you drink more.
- 3. In general, you can eat any foods.** Although breast-fed babies are not allergic to their mother's milk, they can have reactions to substances that appear in the milk from the mother's diet. If your baby is bothered by something you ate, your baby may have a reaction such as excessive crying, stuffy or runny nose, vomiting, diarrhea, cough, or rash on the cheeks or around the bottom.

If a particular food or beverage seems to upset your baby, avoid that substance for a week and then try it again to see if it truly affects your baby. The most common foods in a mother's diet that cause allergic symptoms in nursing infants are cow's milk and other dairy products, peanuts, corn, wheat, eggs, fish, soy, citrus fruits, and tomatoes.

If you think your baby is having a reaction to certain foods you eat, talk to a doctor or dietitian before you eliminate a major food group (such as dairy products or wheat products) from your diet. They can suggest substitute foods that will give you the essential nutrients provided by the foods that bother your baby.

- 4. Continue taking your daily prenatal vitamins.** Remember, however, that vitamin and mineral supplements do not take the place of food. It is better to get your nutrients from a well-balanced diet than to rely on a vitamin and mineral supplement. A nursing mother can take a multivitamin tablet daily if she is not following a well-balanced diet. She especially needs 400 units of vitamin D and 1200 mg of both calcium and phosphorus per day. A quart of milk (or its equivalent in cheese or yogurt) can also meet this requirement.
- 5. Don't drink more than 2 cups of coffee, tea, cola, or other caffeine-containing beverages a day.** Caffeine passes into your breast milk and can make your baby irritable.
- 6. It is best to abstain from alcohol while you are breast-feeding, just as you did during your pregnancy.** Alcohol is readily passed into human milk. Any heavy drinking or daily drinking of even small quantities of alcoholic beverages could hurt your baby. If you have a hospitalized premature or ill newborn, DO NOT drink ANY alcohol. An occasional beer or glass of wine is probably OK, but you should not have more than 1 or 2 a week.
- 7. Do not smoke.** Smoking can decrease your milk supply. Also, the breakdown products from nicotine can pass to your baby in your milk. If you cannot stop smoking altogether, try to cut down. If you must smoke, do it shortly after nursing your baby. Above all, do not smoke in the same room as your baby or even in the house. Breathing your exhaled smoke can hurt your baby.
- 8. If you need to take any medicines, including nonprescription drugs, check with your health care provider or pharmacist.** You need to make sure that the drug is safe for nursing babies. Almost any drug a breast-feeding mother consumes will be transferred in small amounts to her breast milk. Therefore, try to avoid any drug that is not essential, just as you did during pregnancy.

Some commonly used drugs that are safe for you to take while nursing are acetaminophen, ibuprofen, penicillins, erythromycin, cephalosporins, stool softeners, antihistamines, decongestants, cough drops, nosedrops, eyedrops, and skin creams. Aspirin and sulfa drugs can be taken if your baby is more than 2 weeks old AND not jaundiced. Consult your physician about all other drugs. Take drugs that are not harmful immediately after you breast-feed your child so that the level of drugs in the breast milk at the time of the next feeding is low.

Some of the dangerous drugs that can harm your baby are tetracyclines, chloramphenicol, antithyroid drugs, anticancer drugs, or any radioactive substance. Women who must take these drugs should not be breast-feeding or should request a safer form of treatment. Another group of drugs that should be avoided because they can suppress milk production are ergotamines (for migraine), birth control pills with a high estrogen content (most birth control pills are OK), and vitamin B6 (pyridoxine) in large doses.
- 9. Never use illegal or street drugs while you are nursing.** Drug abuse by nursing mothers can be highly dangerous to breast-fed babies.

**10. Check with your doctor before you start a program to lose weight.** Your body uses the fat stored during pregnancy to make breast milk. This is the reason most breast-feeding mothers can expect to lose several pounds each month. However, a strict weight-reduction diet can decrease your milk supply. Attempts to lose weight should be carefully supervised by your doctor while you are breast-feeding.

**Call Your Child's Physician within 24 Hours If:**

- Your baby doesn't seem to be gaining adequately.
- Your baby has less than six wet diapers per day.
- During the first month, your baby has less than 3 bowel movements per day.
- You suspect your baby has a food allergy.
- You need to take a medication that is not mentioned in this discussion.
- Your breasts do not become full (engorged) before feedings by the time your baby is 5 days old.
- You have painful engorgement or sore nipples that do not respond to the recommended treatment.
- You have a fever (also call your obstetrician).

## **Breast-Feeding Problems**

### **Postpartum Breast Engorgement**

**What is postpartum breast engorgement?** Usually on the second to fifth day after you have your baby, you will notice changes in your breasts. They will become larger, somewhat firm, and slightly tender as they begin to produce large amounts of milk. This is called postpartum breast engorgement.

Engorgement is a normal process. However, breast swelling with engorgement may make it difficult for your baby to get milk. Your baby may not be able to latch on correctly and your nipple may become sore. Not releasing the pressure in your breast can cause you to make less milk or to even stop producing milk.

Knowing how to manage engorgement will help you avoid these problems.

**What is the cause?** Postpartum breast engorgement is caused by the hormone changes in your body after delivery. The changes in hormones cause your breasts to start making a lot of milk. Extra blood flowing to the breasts adds to the engorgement.

**How long will it last?** Engorgement usually lasts just a few days until your body gets used to making and releasing milk. The swelling of your breasts makes it seem like you are making more milk than your baby needs. However, getting milk to flow is really the problem with engorgement, rather than making too much milk.

Once your baby is nursing well and your milk is flowing easily, there will be less swelling and firmness. Within a few days, your breasts adjust to your baby's appetite. Then you will then most likely produce as much milk as your baby takes from your breasts. By the end of the first week after delivery, your breasts will have adjusted and will be much less engorged.

## How can I take care of myself?

- 1. Prevention.** Nursing frequently day and night helps reduce breast engorgement. Plan to nurse your baby at least every 2 to 3 hours. Feeding less often is OK at night, but don't allow more than one period of 5 hours to pass between feedings each night. Aim to feed your baby 8 to 12 times every 24 hours. Your newborn should nurse vigorously at least 10 minutes at each breast.
- 2. Managing fullness and discomfort.** Warm your breasts just before nursing. Heat improves blood flow and helps your milk let-down. Thus, a warm shower or warm washcloth on the breasts just before feeding may help relieve engorgement.

Gently massage and press on the firmer areas of your breast while your baby nurses to help empty and soften these areas. Put cool washcloths on your breasts between feedings to help relieve discomfort and reduce swelling.

Some breast-feeding experts recommend using cool cabbage leaves to treat uncomfortable breast engorgement. Many women who have tried cabbage leaves claim the treatment brings relief from discomfort and improves milk flow. (Cabbage has been used for centuries as a folk remedy for a wide variety of ailments.) Whether improvement results from the cool wraps or from a specific property in cabbage is not known. Here is how you can use cabbage leaves for engorgement:

- Put thoroughly washed and dried, crisp, cold, green cabbage leaves over your engorged breasts. You can wear the leaves inside your bra or use them as compresses covered by a cool towel. You can cut holes in the leaves, if necessary, to allow the nipples to stay dry.
- Leave the cabbage leaves in place for about 20 to 30 minutes or until they have wilted. Usually only one or two applications of the leaves are needed to soften the breasts and establish good milk flow. Women who are trying to dry up their milk have used longer periods of time.

- 3. Milk expression during engorgement.** Many women are afraid to pump or express milk while they are engorged because they think it will cause them to make even more milk. However, engorgement is really a problem of poor milk flow, rather too much milk.

If your breasts are so full that it's hard for your baby to latch on correctly, you may want to pump or hand-express some milk before the feeding. Express enough to soften the nipple and areola so your baby can better grasp your nipple and about 1 inch of the surrounding areola.

If your breasts are still uncomfortably full after feeding your baby, pump for a few minutes until your breasts are softer and your milk is flowing better. Reduce the firmness enough to relieve discomfort and produce obvious softening. Encourage your baby to nurse frequently to relieve breast fullness. Soon your baby will probably empty your breasts well at each feeding and you will no longer need to pump excess milk.

Your baby's doctor can tell you if you need to feed your baby any expressed milk. If it is not necessary, the milk you express can be frozen for future use.

**4. Unrelieved engorgement.** Unrelieved engorgement is considered to be a breast-feeding emergency because residual milk and sustained pressure on the milk-producing glands can rapidly decrease your milk supply. Thus, if your breasts are so full that your baby cannot latch on or if your baby is not nursing well after your milk has come in abundantly, you will need to get help with breast-feeding and perhaps rent an electric breast pump. Use the pump to express your milk at regular feeding times. Pumping your breasts will allow you to relieve uncomfortable fullness and to keep producing abundant milk. The pumped milk can be fed to your baby until he or she learns to breast-feed well.

## **Sore Nipples**

Breast-feeding should be a comfortable and enjoyable experience. Unfortunately, sore nipples are a common complaint among breast-feeding mothers. Often mothers quit nursing their babies early because of sore nipples, but this doesn't have to happen. Sore nipples usually can be prevented or treated.

Mild nipple discomfort at the beginning of feedings during the first few days of breast-feeding usually needs no treatment. However, nipple pain that is severe or lasts throughout a feeding or persists for more than a week is not normal and should be evaluated by your doctor or a lactation consultant.

**What causes sore nipples?** The most common cause of severe nipple soreness is improper positioning of your baby's mouth on your breast. The particular size and shape of your nipples and your baby's mouth can affect your baby's latching-on technique. In addition, your infant's unique sucking habits can contribute to nipple discomfort.

Other possible causes of nipple pain are an infection of the nipples (yeast or bacterial), a breast infection, or improper nipple skin care.

**What problems can sore nipples cause?** If your baby is latching on to your breast incorrectly, he may not be getting enough milk. Also, nipple pain may cause you to postpone nursings or may decrease your let-down reflex and reduce milk flow. This combination of factors can easily cause a drop in your milk supply. As a result, your baby may not gain weight well. Sore nipples and low milk supply often go hand-in-hand.

**How are sore nipples treated?** The following recommendations should help within a day or so.

**1. Make sure your baby is positioned correctly to nurse.** Support your breast with four fingers below and your thumb above. Place your fingers far enough behind the darkened area around your nipple (areola) so they won't touch your baby's mouth when she attaches. When your baby opens her mouth wide, quickly pull her toward you so she grasps both your nipple and as much surrounding areola as possible.

- Do not let your baby take only the tip of your nipple.
- Make sure the baby gets enough of the lower part of the areola in her mouth. Not doing so is a common cause of sore nipples.
- During the feeding hold your breast from below so the nipple and areola aren't pulled out of your baby's mouth by the weight of the breast.
- Make sure your baby is facing you chest-to-chest.

**2. Begin a feeding on the less sore nipple to trigger your let-down reflex and start milk flowing.** Babies suck harder at the beginning of feedings. After your baby has nursed briefly and milk flow has begun, move her to the second breast. This should make nursing more comfortable because the baby will suck less vigorously once milk starts to flow. However, as soon as possible, resume switching the breast you start each feeding with to prevent a lopsided milk supply.

**3. Frequent shorter feedings are preferable to less frequent lengthy feedings.** If one nipple is extremely sore, temporarily limit feedings to 10 minutes on that side.

**4. Keep your nipples dry.** Gently pat your nipples dry with a clean cloth after nursing or let your nipples air-dry for 15 to 20 minutes. Cleanse your nipples with soap and water when you bathe. If you wear breast pads, change them as soon as they become wet.

Don't go to extremes and dry your nipples too much. For example, don't dry them with a hair dryer and don't expose them to air for a long time if you live where the humidity is low. Too much dryness can worsen the condition of the skin.

**5. If you have cracks or other breaks in the skin, keep your nipples covered with a soothing emollient.** USP Modified Lanolin (medical grade) is best. Put a fresh coating on your nipples after each feeding. Also, wearing wide-based breast shells over your nipples between nursings can reduce the discomfort and speed up healing by preventing direct contact with your bra.

**6. Use a pump to express your milk if the pain is so severe that you cannot nurse your baby.** You can stop nursing and pump milk for 2 to 3 days while your nipples heal. You can rent a hospital-grade electric pump temporarily to express your milk comfortably. *Pumping* is a convenient way to empty your breasts and maintain or increase your milk supply while your nipples heal. Other types of breast pumps generally are not as comfortable or effective as a rented hospital-grade electric pump.

**7. Watch for signs of a breast infection.** A cracked nipple may make you more susceptible to getting a breast infection (mastitis). Be on the lookout for any signs of infection. The signs are described below in the section on when to call your doctor.

**Call your doctor immediately if:**

- You have any of the following symptoms in addition to sore nipples: chills, fever, headache, flu-like symptoms, or pain or redness in your breast. These symptoms suggest you may have a breast infection (mastitis). The infection requires **prompt** treatment with antibiotics.

**Call your doctor during office hours if:**

- Your nipples sting or burn and you have shooting pains in your breast, especially after nursing. You may have a yeast infection of your nipples. A yeast infection requires treatment with medication. Babies can get yeast infections in their mouths and diaper areas.
- The nipple pain inhibits your let-down reflex. In this case, your doctor may prescribe a pain medication.

**Call your baby's doctor during office hours if:**

- Your baby is not satisfied after most nursings. Your baby may not be satisfied because your milk supply is low or because your baby is not emptying your breasts. After weighing your baby, the doctor can decide whether you need to change your feeding schedule or offer your baby supplemental breast milk or formula. You may need to use an electric pump temporarily to express any milk left after nursings. Pumping will help increase your milk supply.
- Your nipples have a yeast infection, you see white patches in your baby's mouth, or your baby has had a diaper rash for 3 or more days. In this case, your baby may need to be treated for a yeast infection.

**Plugged Ducts**

**What is a plugged duct?** A plugged duct is when one or more of the milk ducts become blocked. It will feel like a hard, tender lump in your breast. Incomplete emptying of the breast usually causes plugged ducts. Stress, fatigue, or a tight bra can also cause a plugged duct. Some women are more prone to plugged ducts than others.

Because a plugged duct can lead to a breast infection, it needs to be unplugged as soon as possible.

**How can I unplug the duct?**

- Nurse on the tender side first when the baby is hungriest and sucks more strongly. This will ensure complete emptying of that breast.
- Massage the breast with the lump, expressing extra milk and trying to unplug the duct. Between nursing sessions apply moist heat to the breast. (The best way is to soak in a hot bath while massaging your breast and expressing milk. A hot shower or a heating pad is also helpful.)
- Be persistent! With a plugged duct you have to work with massage, expression, nursing, and moist heat until it clears.
- Sleep on your side instead of your back to assist the flow of milk down into your breasts.
- Since stress can be an important factor in plugged ducts, make sure you get plenty of rest and relaxation.
- When the plugged duct unclogs, you may feel a burning or pinching.

**WARNING:** if redness, a painful lump, and/or a fever and flu-like feeling accompany a plugged duct, you could have a breast infection. Call your physician immediately!

**How can I prevent plugged ducts?**

- Nurse frequently.
- Empty each breast at each nursing.
- Avoid tight or poorly fitting bras.
- Sleep on your side instead of back. Get plenty of rest.

**Breast Infection (Mastitis)**

Mastitis is an infection in the breast. The condition usually occurs in women who are breast-feeding. You may have both general symptoms of illness and breast symptoms including: flu-like feeling, fever, chills, headache, breast pain, breast redness, breast firmness, nipple or areolar pain and/or difficulty getting milk to flow.

Call your physician promptly if you have any symptoms of mastitis. The sooner you start treatment, the sooner you will feel better. Prompt treatment may prevent complications, such as a breast abscess (a pocket of pus requiring drainage).

**What is the cause?** Bacteria usually cause breast infections. Bacteria are normally present on the nipple and in a baby's mouth. They can enter the breast through a cracked nipple or the milk ducts and cause mastitis.

Many factors can make a breast-feeding mother susceptible to mastitis. One of the principal factors is inadequate drainage of milk from your breasts. Poor emptying can occur by allowing too much time to pass between feedings. Also, milk may not drain well if a duct is clogged, or a tight-fitting bra may obstruct milk flow.

Injury to the breast can make a breast-feeding woman more susceptible to mastitis. A baby teething on the breast or incorrectly latching on to the nipple may cause the injury. Use of a breast pump that generates excessive vacuum can also injure the breast.

Exhaustion may contribute to mastitis. For example, returning to work, not getting enough sleep, and having house guests may tire a new mother.

### **What is the treatment?**

- 1. Take the entire antibiotic your doctor prescribes even if you feel much better after a few days.** Mastitis is usually treated with an antibiotic for 10 days.
  - 2. Rest and stay in bed as much as possible.** Get all the help you can for at least the next 2 days.
  - 3. Drink plenty of fluids,** especially if you have a fever.
  - 4. Take medicine for the pain if necessary.** You will probably need pain medication during the first 2 days of your illness. Ask your doctor for a prescription if necessary. Ibuprofen is a good choice for over-the-counter pain medication. Only very small amounts of ibuprofen are excreted in breast milk.
  - 5. Nurse more often,** especially from the side that is infected, to keep your breasts well emptied. You do not have to wean your baby if you have mastitis. In fact, you should nurse more often. You may need to put moist heat on the affected area of your breast before nursing to help start milk flow. For example, put a warm washcloth on the breast, take a warm shower, or submerge the breast in a basin or tub of warm water. You can begin feedings on the side that is not infected and then move your baby to the infected breast once your let-down has been triggered.
- If you are pumping milk for a sick or premature hospitalized baby when you develop mastitis, discard the milk collected from the infected side until you are well.
- 6. Pump your breasts if necessary.** If nursing your baby is too painful or doesn't relieve your breast fullness, you may need to rent an electric breast pump. Often an electric pump will comfortably and efficiently empty your breasts.

You may need to rent a breast pump if:

- The infected breast is still not emptying well even though you have followed the treatment suggestions.
- Nursing your baby from the infected breast is too painful.
- Your baby refuses to nurse from the infected breast.

### **When should I call the doctor?**

#### **Call YOUR doctor during office hours if:**

- Your symptoms are not better within 48 hours after you start taking antibiotics.
- A tender breast lump develops that is not relieved by nursing.

#### **Call your BABY’S doctor during office hours if:**

- You think your milk supply is decreasing.
- Your baby shows any signs of illness such as fever, poor feeding, tiredness, irritability, trouble breathing, or a rash. Call any time if you are worried.
- Your baby develops a diaper rash while you are taking antibiotics. The rash may be due to a yeast infection and may require treatment with a medication.

## **Introducing a Bottle to a Breast-Fed Baby**

In an ideal world, breast-feeding mothers would be able to nurse their babies at every feeding and never need to give a bottle. However, once breast-feeding is going well, many mothers need their babies to drink from a bottle occasionally. Women who are going to work outside the home want their babies to become familiar with bottle-feeding so others can feed their babies during the workday. Mothers may choose to have their partners or other people occasionally feed pumped breast milk with a bottle. Rarely, mothers and babies need to be separated as a result of illness.

Some breast-fed babies readily accept a bottle, while others are very resistant to new methods of feeding. Many breast-feeding mothers become frustrated and discouraged when their baby refuses to drink from a bottle. The following suggestions have been found to be helpful in encouraging breast-fed infants to accept a bottle.

- 1.** The most important thing to remember is to stay calm when you offer a bottle to your baby. Your baby probably will resist a bit at first by turning away, grimacing or making a face, or pushing the nipple away with her tongue. Don’t force the bottle at any time and stop your efforts right away at the first sign that your baby is becoming unhappy with this lesson.
- 2.** Plan a time when you can devote 10 to 15 uninterrupted minutes to try the bottle. Your baby will feel the pressure if you are rushed.
- 3.** Choose a time when your baby is alert and perhaps slightly hungry so she will be motivated to learn a new way to receive milk. On the other hand, avoid offering a bottle when your baby is very hungry. An upset, frantically hungry baby will be in no mood to try something new.

4. Offer milk that you have pumped from your breasts earlier in the day. Warm the milk first, taking care not to overheat the milk. Because the bottle nipple smells and tastes different from your breast nipple, having a familiar fluid to drink may encourage your baby to try the new feeding method.
5. No particular bottle or nipple works best for every baby. If your baby uses a pacifier, she might prefer a nipple shaped like her pacifier nipple. Stick with one nipple for several days before switching to another. Trying a wide variety of nipples probably will just confuse your baby more.
6. Breast-fed babies often accept a bottle more readily if someone offers it other than the mother. If the nursing mother tries to give the bottle, the baby may protest and turn toward the breast to nurse. On the other hand, some breast-fed babies actually accept the bottle better when they are in their own mother's arms and can hear her reassuring voice.
7. Go slowly and gently, first touching the baby's lips with the nipple and watching her reaction. Don't force the nipple past her lips. Instead, let your baby draw the nipple into her mouth at her own pace.
8. Express a little milk from the bottle nipple onto the baby's lips or tongue. Remove the nipple before your baby protests. Keep a smile on your face and keep talking in a reassuring tone the whole time. Babies notice their mothers' and caretakers' facial expressions and take their cues from you.
9. If your baby starts to get upset, try to calm her down by talking in a reassuring tone. As soon as she starts to settle down, remove the nipple. Avoid letting her get very upset and then taking the nipple away. This will teach her that if she protests enough you will remove the nipple. It's better to remove the nipple before she becomes upset or to try to calm her with your voice before you remove the nipple.
10. If your baby is not upset or distressed by the bottle, move the nipple a little further into the baby's mouth and let her explore it with her mouth. Keep smiling and offering encouraging words in a soothing voice. Do not stick the bottle into your baby's mouth with too much force. This may cause the baby to gag.
11. Don't spend more than about 10 minutes trying the bottle. Stop sooner if you or your baby is getting frustrated. It's better to end the session on a positive note and try again tomorrow.

## **Weaning From Breast to Bottle**

If you need to or want to stop breast-feeding, it is best to wait until your baby is at least 4 weeks old. If you are going to use breast milk in the bottles instead of formula, it is best to wait until your baby is at least 4 weeks so that your milk supply is well established and you can effectively pump your breast milk.

If your baby is older than 9 months, he or she is probably ready to wean straight to a cup rather than to a bottle.

If you are using formula:

- Be sure to watch carefully how your baby tolerates the formula. Look for rashes, spitting up, and/or bowel problems. If any appear, you should ask your doctor and ask if you need to change formulas.
- Use iron-fortified formula until the baby is at least 1 year old to avoid iron-deficiency anemia.

If you are using breast milk:

- Make sure you have enough breast milk pumped for each bottle feeding and that you store and warm the milk properly.
- Pump your breasts around the time you would have nursed your baby. That way you can maintain a good supply of milk.

### **How do I wean my baby?**

- **Take your time:** Plan ahead and give yourself and your baby plenty of time. Gradual weaning gives your baby time to adjust. It also allows your milk supply to diminish gradually and saves you from engorged breasts. Some mothers experience a mild depression when weaning as a result of changes in hormones related to their milk production. This is especially likely to happen if the weaning is done too quickly.
- **Hold your baby:** Hold and cuddle your baby while giving him a bottle. Try to make bottle feeding as warm and comfortable as nursing was. Don't prop your baby up with a bottle in an infant seat and leave. Bottle feeding also gives the fathers, brothers, and sisters a chance to feed and relate to the baby and it spreads out the work!
- **Eliminate 1 feeding at a time:** The speed of weaning will depend on your baby. In general, however, it is best to substitute the bottle for one nursing session at a time. After you have replaced a nursing session with a bottle, wait 5 to 7 days. Then, if the baby is adjusting well, substitute a bottle for another nursing session.
- The early morning and late evening nursing sessions are usually the most difficult for your baby to give up. Wean the baby from these last. You will soon learn which feedings are your baby's least favorite and when his appetite is generally lowest. Replace these nursings first.

**What if my breasts become engorged?** If your breasts become engorged because you are not nursing as much, allow your baby to suck 15 to 30 seconds from each breast to relieve your discomfort. Make sure that you don't nurse any longer, however, or you will trigger your breasts to produce more milk and the engorgement will get worse.

**What if I have problems with weaning?** Setbacks in weaning can be caused by many things, including stress, major changes in meal or bed times, or illness. If such setbacks occur, wait until the situation improves or the illness is over, and then continue the weaning process. Call your baby's doctor if you have any questions or concerns.

## **Formula Feeding**

Infant formulas have been designed to meet the nutritional needs of your infant by providing all known essential nutrients in their proper amounts. Most formulas are derived from cow's milk. A few are derived from soybeans and are for infants who may be allergic to or have difficulty digesting the type of protein in cow's milk.

Most commercial infant formulas are available in three forms: powder, concentrated liquid, and ready-to-serve liquid. Powder and ready-to-serve liquid are the most suitable forms when formula is used to supplement breast milk. Powder and concentrated liquid formulas are less expensive per feeding than ready-to-serve formulas.

The majority of infant formulas contain lactose (milk sugar) as the only carbohydrate, just as breast milk does. Lactose aids digestion and promotes normal bowel function and healthy tissue formation.

A mixture of easily digested fats is also contained in the formulas. These help protect your baby's skin and aid the absorption and utilization of certain vitamins.

All known vitamins necessary for the development and growth of your baby are provided by infant formulas, including vitamin A for building body cells and good vision; the B vitamins for maintaining the nervous system, skin, and tissues; vitamin C for healthy gums and teeth; vitamin D for strong bones and teeth; and vitamin E for proper functioning of red blood cells.

Vital minerals such as calcium and phosphorus for developing bones and teeth, as well as iron for healthy blood and resistance to infection, are also among the nutrients supplied in formulas. The American Academy of Pediatrics recommends that all infants be given a commercial formula that is iron-fortified. These formulas do not contain enough iron to cause diarrhea, constipation, abdominal cramps, or any other symptoms. With iron-fortified formulas, no supplementary vitamins or minerals are needed.

## **Cow's milk**

Whole cow's milk should not be given to babies before 12 months of age because of increased risks of iron deficiency anemia and allergies. Skim or low-fat milk should not be given to babies before they are 2 years old because the fat in whole milk is needed for rapid brain growth.

## **Preparing formulas**

Mix concentrated liquid formula with water in a ratio of one to one. Mix each level scoop of powdered formula with 2 ounces of water. Never make the formula for your baby more concentrated by adding extra concentrated liquid or extra powder. Never dilute the formula by adding more water than specified. Careful measuring and mixing ensure that your baby receives the proper concentration of formula.

If you use tap water for preparing formula, use only water from the cold water tap. Let the water run for 2 minutes before you use it. (Old water pipes may contain lead-based solder and lead dissolves more in warm water or standing water.) Fresh, cold water is safe.

If you make one bottle at a time, you don't need to use boiled water. Just heat cold tap water to the preferred temperature. Most city water supplies are quite safe.

If you prefer to prepare a batch of formula, you must use boiled or distilled water and closely follow the directions printed on the side of the formula can.

## Formula temperature

In the summertime, many children prefer cold formula. In the wintertime, most prefer warm formula. By trying formula at various temperatures you can probably find out what your child prefers. If you do warm the formula, check the temperature of the formula before you give it to your baby. If it is too hot it will burn your baby's mouth. Be especially careful if you heat the formula in a microwave because the formula can get too hot very quickly.

## Feeding your baby

**1. Schedules and amounts.** Your physician will tell you when and how often to feed your baby.

In general, your baby will probably need six to eight feedings per day for the first 3 weeks, five to six feedings per day from 1 to 3 months, four to five feedings per day from 3 to 7 months, and three to four feedings per day from 7 to 9 months. If your baby is not hungry at some feedings, increase the time between feedings.

Newborns usually start with 1 ounce per feeding, but by 7 days they can take 3 ounces. The amount of formula that most babies take per feeding (in ounces) can be calculated by dividing your baby's weight (in pounds) in half. For example, if your baby weighs 8 pounds, your baby will probably drink 4 ounces of formula per feeding. No baby should drink more than 32 ounces of formula a day. Overfeeding can cause vomiting, diarrhea, or excessive weight gain.

**2. Position.** Feeding should be a relaxing time -- a time for you to provide both food and comfort for your baby. Make sure that both you and the baby are comfortable:

- Your arm supported by a pillow.
- Baby in a semi-upright feeding position supported in the crook of your arm. This position reduces choking and the flow of milk into the middle ear.
- The bottle tilted so that the nipple and the neck of the bottle are always filled with formula. (This prevents your baby from taking in too much air.)
- Talk to your baby and hold her close.

**3. Length of feeding.** Gently remove the bottle from time to time to let your baby rest. A feeding shouldn't take more than 20 minutes. If it does, you are overfeeding your baby or the nipple is clogged. A clean nipple should drip about 1 drop per second when the bottle of formula is inverted.

**4. Formula storage.** Prepared formula should be stored in the refrigerator and must be used within 48 hours. Prepared formula left at room temperature for more than 1 hour should be thrown away. At the end of each feeding, throw away any formula left in the bottle.

## **OTHER NEWBORN ISSUES**

### **Burping**

Burping your baby helps remove air swallowed during feeding. You can wait until the end of the feeding or burp at intervals during the feeding. You'll soon be able to tell if your baby needs frequent burping. Here are three good methods:

- Hold your baby so her head rests on your shoulder and her chest is against yours. Pat her back or rub it upward with your hand.
- Lay your baby face down on your lap. Rub or pat her back.
- Hold your baby in a sitting position on your lap, with her side toward you. Support her head and back with one hand, chin and chest with the other. Then gently rock her back and forth as if helping her "take a bow."

Your baby may spit up small amounts of formula or breast milk too. No cause for alarm. It happens to all babies. You may be able to reduce the spitting up by burping your baby more often or longer during and after feedings.

### **Bowel Movements**

There is a wide range of normal stooling patterns. Some infants stool with each feeding. Others may go two or three days before a bowel movement. Your baby's stools will probably change in color, softness, and frequency from time to time. Usually, breast-fed infants have liquid, seedy, yellow or mustard-colored stools. If you're breast-feeding your baby, don't take runny stools as a sign of diarrhea. The stools of formula-fed infants are yellowish-tan. All babies sometimes have green, brown or gray-colored stools. However, if the stool is green, runny and frequent, overflowing the diaper, it's usually a sign of diarrhea.

As long as your baby seems happy and content, is eating normally, and has no signs of illness, don't worry about minor changes in the stools. Almost all babies will strain and appear uncomfortable when they stool. Again, if the texture is soft, this is very normal and requires no attention. If the stool is hard, and especially if there is evidence of blood streaking, give two ounces of half-strength prune juice twice daily. If these measures are unsuccessful, give us a call. We want to discourage the frequent use of suppositories, and we do not recommend enemas for infants. Similarly, laxatives are rarely necessary.

### **Bathing**

For the first few days after your baby comes home, bath time can consist of a gentle once-over with a soft, damp wash cloth — warm, of course — and a mild soap. Any basic non-perfumed soap is acceptable such as Dial, or Johnson's. Actually you use much more water than soap in the bath. Too much soap is drying. Regular baths should wait until what's left of the umbilical cord has come off — and, in the case of boys, until the circumcision heals. Once your baby is ready for full-fledged baths, be sure the room is warm, with no drafts, and the water is about 85°. When you stick your elbow in the water, it should feel warmer than your skin but not actually hot. Keep the parts of your baby not being washed covered with a warm towel.

Your baby may find bath time a highlight of his day, if you take a few precautions to keep soap out of his eyes and mouth and make him comfortable. Wash your baby's face with plain water, and a soft cloth. Gently clean your baby's face and scalp when bathing to remove excessive oil and skin debris, working from front to back to keep the soap out of his eyes. Your infant's skin has its own protective oils, so commercial oils, lotions, and powders are not usually necessary. There is no need to wash your baby every day. He is not getting dirty playing in the mud. Every two to three days is sufficient.

Don't try to clean any areas inside his mouth until he starts getting teeth; then you can use a soft cloth and water to clean them.

### **Eyes**

Often mucus collects on the eyelids and lashes. A moist cotton ball is usually sufficient to remove the mucus. If there is pus or if the whites of the eyes or tissues about the eyes are red or swollen, we want to see the baby.

### **Nose**

Sneezing is the baby's way of clearing the mucus, which is often present. If this is not sufficient and the nose remains stuffed, squirt several drops of saltwater nose drops (½ teaspoon of salt in a measuring cup of water) into one nostril. Wait 15-30 seconds, then aspirate with a rubber ear syringe. Repeat in the other nostril. The best time for this procedure is prior to feedings, since a baby depends on easy nose breathing while he sucks.

### **Ears**

With a cotton ball, wipe away any yellow-orange earwax that's collected in the visible part of his ear. Only clean the outside. Do not insert Q-tips into the ear canal. You cannot tell how deep you can go, and more often than not you push the wax farther down or damage the eardrum.

### **Umbilical Cord**

Six times a day, clean the area with rubbing alcohol for several minutes. Use a cotton swab and remove all dried pus or debris. The umbilical area does not have any sensation, so the alcohol won't sting. If the cord is still present, clean underneath it by lifting it up. If the cord has fallen off, pour some alcohol into the depression and remove it after 2 or 3 minutes. It takes that long to kill bacteria. Air exposure and dryness help healing, so be sure to keep the diaper folded down below the cord area.

## **BREATHING**

Babies tend to breathe with an irregular pattern of fairly rapid shallow breaths, followed by several seconds of no visible respiration. This is referred to as **periodic breathing**. It is normal, and does not signify true apnea. It is caused by an immature breathing regulation center in the newborn's brain. This phenomenon specifically does not involve any color change - the baby stays pink. Touching your baby gently will stimulate him to breathe again.

**Sneezing** is normal and expected in newborns. Dry, possibly dust-laden air is irritating to the newborn nasal membranes for the first few weeks. This does not signify allergies or illness.

**Nasal stuffiness** is caused largely by the same factors that cause sneezing, with an added twist: the soft palate (the flap of tissue at the back of the roof of the mouth, from which hangs the uvula) is supposed to seal off the rear of the nasal passages during swallowing or spitting up. This system doesn't work well in newborns. There is considerable leakage and regurgitation of milk into the nasal passages from the rear, causing stuffiness and some difficulty breathing. Additionally the cartilage forming the nose is soft and flexible and can vibrate with breathing mimicking the noise of a stuffy nose. When symptoms are severe and inhibit feeding, a few drops of saline in each nostril followed by good suctioning, gives temporary relief.

Newborns have **hiccups** quite often. No one knows with absolute certainty why this is, but hiccups are caused by reflex stimulation of the vagus nerve to the diaphragm. We assume the frequency of hiccups in newborns is a feature of their neurologic immaturity. Hiccups are harmless, do not bother the baby in the least, and go away in a few weeks.

## Crying

Crying is a baby's way of communicating. It conveys a variety of messages, which, with experience, you will come to recognize. At times an episode may reflect the need for a diaper change; at others, it may signify hunger; some others may tell of discomfort. There will also be periods when you will be unable to comprehend the cause for the tears. This is not uncommon. It does not necessarily mean there is anything wrong with you, the milk, or even the baby. It may just be normal.

There are a number of things you can do to comfort your baby:

- Give the baby something to suck, such as a pacifier.
- Lengthen feeding times.
- Give the baby more physical contact and movement. Walk, rock or pat him.
- Take the baby for a stroller ride or car ride.
- 'Bundle' the baby (wrap him snugly in a blanket) or raise the temperature in his room a little if you think it's too cool.
- Change his position. For example, move him from his back to his side or vice versa.

If all else fails just let him cry. He may need to let off steam. Often babies fall asleep after a good cry — so allow him up to 20 minutes on his own.

### Prevent Shaken Baby Syndrome

Shaken baby syndrome describes the serious injuries that can occur when an infant or toddler is severely or violently shaken. These children, especially babies, have very weak neck muscles and do not yet have full support for their heavy heads. When they are shaken, their fragile brains move back and forth within their skulls. This can cause serious injuries such as:

- blindness or eye damage
- delay in normal development
- seizures
- damage to the spinal cord (paralysis)
- brain damage
- death

Shaken baby syndrome usually occurs when a parent or other caregiver shakes a baby because of anger or frustration, often because the baby would not stop crying. Shaken baby syndrome is a serious form of child abuse. Parents should be aware of the severe injuries that shaking can cause. Remember that it is never okay to shake a baby.

If you or your caregiver severely or violently shakes your baby because of anger or frustration, the most important step is to get medical care right away. Immediately take your child to the pediatrician or emergency room. Don't let embarrassment, guilt, or fear get in the way of your child's health or life.

If your baby's brain is damaged or bleeding inside from severe shaking, it will only get worse without treatment. Getting medical care right away may save your child's life and prevent serious health problems from developing.

Be sure to tell your pediatrician or other doctor if you know or suspect that your child was shaken. A doctor who is not aware that a child has been shaken may assume the baby is vomiting or having trouble breathing because of an illness. Mild symptoms of shaken baby syndrome are very much like those of infant colic, feeding problems, and fussiness. Your pediatrician should have complete information so that he or she can treat your child properly.

### **When Your Child Cries, Take a Break— Don't Shake!**

Taking care of an infant can be challenging, especially when an end to the crying seems nowhere in sight. If you have tried to calm your crying child but nothing seems to work, it's important to stay in control of your temper. Remember that it's never okay to shake, throw, or hit your child. If you feel as though you could lose control:

- Take a deep breath and count to 10.
- Take time out and let your baby cry alone.
- Call someone close to you for emotional support.

Call your pediatrician. There may be a medical reason why your child is crying.

## **Circumcised Penis**

**What is circumcision?** At birth, boys have skin that covers the end of the penis, called the foreskin. Circumcision surgically removes the foreskin, exposing the tip of the penis. A doctor usually performs circumcision in the first few days of life. An infant must be stable and healthy to safely be circumcised.

**What should I expect for my son after circumcision?** After the circumcision, the tip of the penis may seem raw or yellowish. If there is a bandage, it should be changed with each diapering to reduce the risk of the penis becoming infected. Petroleum jelly should be used to keep the bandage from sticking. Sometimes a plastic ring is used instead of a bandage. The plastic ring that is left on the tip of the penis usually drops off within 5 to 8 days. It takes about 1 week to 10 days for the penis to fully heal after circumcision.

**Are there any problems that can happen after circumcision?** Problems after a circumcision are very rare. However, call your pediatrician right away if

- Your baby does not urinate normally within 6 to 8 hours after the circumcision.

- There is persistent bleeding.
- There is redness around the tip of the penis that gets worse after 3 to 5 days.

It is normal to have a little yellow discharge or coating around the head of the penis, but this should not last longer than a week.

## **Uncircumcised Penis**

**What is foreskin retraction?** Sometime during the first several years of your son's life, his foreskin, which covers the head of the penis, will separate from the glans. Some foreskins separate soon after birth or even before birth, but this is rare. When it happens is different for every child. It may take a few weeks, months, or years.

After the foreskin separates from the glans, it can be pulled back away from the glans toward the abdomen. This is called *foreskin retraction*.

Most boys will be able to retract their foreskins by the time they are 5 years old, yet others will not be able to until the teenage years. As a boy becomes more aware of his body, he will most likely discover how to retract his own foreskin. But *foreskin retraction should never be forced*. Until separation occurs, do not try to pull the foreskin back especially an infant's. Forcing the foreskin to retract before it is ready may severely harm the penis and cause pain, bleeding, and tears in the skin.

**What is smegma?** When the foreskin separates from the glans, skin cells are shed. These skin cells may look like whitish lumps, resembling pearls, under the foreskin. These are called *smegma*. Smegma is normal and nothing to worry about.

**Does my son's foreskin need special cleaning?** Your son's intact or uncircumcised penis requires no special care and is easy to keep clean. When your son is an infant, bathe or sponge him regularly and wash all body parts, including the genitals. Simply wash the penis with soap and warm water. Remember, do not try to forcibly retract the foreskin.

If your son's foreskin is separated and retractable before he reaches puberty, an occasional retraction with cleansing beneath will do. Once your son starts puberty, he should retract the foreskin and clean beneath it on a regular basis. It should become a part of your son's total body hygiene, just like shampooing his hair and brushing his teeth. Teach your son to clean his foreskin in the following way:

- Gently pull the foreskin back away from the glans.
- Rinse the glans and inside fold of the foreskin with soap and warm water.
- Pull the foreskin back over the head of the penis.

**Is there anything else I should watch for?** While your son is still a baby, you should make sure the hole in the foreskin is large enough to allow a normal stream when he urinates. Talk to your pediatrician if any of the following occurs:

- The stream of urine is never heavier than a trickle.
- Your baby seems to have some discomfort while urinating.
- The foreskin becomes considerably red or swollen.

## Extra Water

Babies do not routinely need extra water. Formula provides all the calories and water they need. Supplemental water bottles only takes away extra calories they need for growth.

## Sleeping

Newborn babies sleep a lot, usually waking up every 2 to 4 hours for feedings. At about 2 months of age, they generally start sleeping through the night, although a few cooperative babies start sooner. Sleeping through the night means different things to parents with newborns than to the rest of the world. Sleeping from midnight to 6AM is a good night. You may have heard that starting solid food will make a baby sleep easier: there's no evidence that this is true.

Between 5 and 7 months of age, your baby may disappoint you by starting to wake once again during the night. This isn't backsliding. It's a normal developmental phase. Let her stay in her bed, comfort her, pat her on the back and change her if needed. The pattern of nighttime sleeping will soon return.

### Sleep Problems

Newborn infants have irregular sleep cycles, which take about 6 months to mature. While newborns sleep an average of 16 to 17 hours per day, they may only sleep 1 or 2 hours at a time. As children get older, the total number of hours they need for sleep decreases. However, different children have different needs. It is normal even for a 6 month old to wake up briefly during the night, but these awakenings should only last a few minutes and children should be able to go back to sleep on their own. Here are some suggestions that may help your baby (and you) sleep better at night:

- 1. Try to keep her as calm and quiet as possible.** When feeding or changing your baby during the night, avoid stimulating her or waking her up too much so she can easily fall back to sleep.
- 2. Don't let your infant sleep as long during the day.** If she sleeps for large blocks of time during the day, she will be more likely to be awake during the night.
- 3. Put your baby into the crib at the first signs of drowsiness.** Ideally it is best to let the baby learn to relax and settle herself to sleep. If you make a habit of holding or rocking her until she falls asleep, she may learn to need you to get back to sleep when she wakes up in the middle of the night. This may interfere with her learning to settle herself and fall asleep alone.
- 4. Try to avoid putting your baby to bed with a pacifier.** Your baby may get used to falling asleep with it and have trouble learning to settle herself without it. Pacifiers should be used to satisfy the baby's need to suck, not to help a baby sleep. If your baby falls asleep with a pacifier, gently remove it before putting her in bed.

## **5. Ideally, by a few weeks of age a baby should sleep in a separate room from his parents.**

If your baby is ill, these suggestions should be relaxed. After she feels better, begin to reestablish sleep patterns.

### **Sleep position and SIDS**

Parents and caregivers should now consider placing healthy infants on their backs when putting them down to sleep. This is because recent studies have shown an increased incidence of Sudden Infant Death Syndrome (SIDS) in infants who sleep on their stomachs. There is no evidence that sleeping on the back is harmful to healthy infants.

#### **Keep the following points in mind:**

- Placing a child to sleep on the back has the lowest risk and is preferred. Sleeping on the side, however, is a reasonable alternative and is safer than sleeping on the stomach.
- Do not place your infant to sleep on soft surfaces or with pillows or stuffed toys. They could cover your child's *airway*.
- This recommendation is for healthy infants. Some infants with certain medical conditions or malformations may need to be placed on their stomachs to sleep. Talk to your pediatrician about which sleeping position is best for your child.
- This recommendation is for *sleeping* infants. A certain amount of "tummy time," while the baby is awake and observed, is recommended.

## **Sucking - Thumbs, Fingers, and Pacifiers**

Does your baby suck his thumb or use a pacifier? Don't worry, these habits are very common and have a soothing and calming effect. The need to suck is present in all infants. Some infants suck their thumbs even before they are born, and some will do it right after being born.

### **Thumb and finger sucking**

Thumb and finger sucking is normal for young children. Most children suck their thumbs or fingers at some time in their early life. Many thumb or finger suckers stop by age 6 or 7 months. The only time it might cause you concern is if it goes on beyond 6 to 8 years of age or affects the shape of your child's mouth or teeth. If you see changes in the roof of your child's mouth (palate) or in the way the teeth are lining up, talk to your pediatrician or pediatric dentist.

Friends, brothers, sisters, and relatives tease children who suck their thumbs past 6 to 8 years often. Sometimes these comments are enough to get the child to stop. If not, talk to your pediatrician about other ways to help your child stop.

### **Pacifiers**

Many parents have strong feelings about pacifiers. Some oppose their use because of the way they look. Some mothers are afraid their children will develop "nipple confusion". Some resent the idea of "pacifying" a baby with an object. Others believe that using a pacifier can harm a baby. This is not true. Pacifiers do not cause any medical or psychological problems. If your baby wants to suck beyond what nursing or bottle-feeding provides, a pacifier will satisfy that need.

A pacifier should not be used to replace or delay meals. Offer a pacifier only after or between feedings, when you are sure your baby is not hungry. If your child is hungry, and you offer a pacifier as a substitute, he may become so upset that it interferes with feeding. It may be tempting to offer your child the pacifier when it is easy for you. However, it is best to let your child decide whether and when to use it.

Some babies use a pacifier to fall asleep. The trouble is, they often wake up when it falls out of their mouths. Once your baby is older and has the skill to find and replace it, there is no problem. Until then, your child may cry for you to find the pacifier. **Do not attempt to solve this problem by tying 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.** Babies who suck their fingers or hands have a real advantage here, because their hands are always readily available.

### **What to Look for When Shopping for a Pacifier**

- Look for a one-piece model that has a soft nipple (some models can break into two pieces).
- The shield should be at least 1 1/2 inches across, so a baby cannot put the entire pacifier into her mouth. Also, the shield should be made of firm plastic with air holes.
- Boil it frequently until your baby is 6 months old so that your child is not exposed to germs. After that, your baby is less likely to get an infection, so you can just wash it with soapy warm water and rinse it in clear water.
- Pacifiers come in two sizes, one for the first 6 months and another for children after that age. For your baby's comfort, make sure the pacifier is the right size.
- You will also find a variety of nipple shapes, from squarish "orthodontic" versions to the standard bottle type. Try different shapes until you find the one your baby prefers.
- Buy some extras. Pacifiers have a way of getting lost or falling on the floor or street when you need them most.
- *Never tie* a pacifier around your baby's neck or hand, or to your child's crib. The danger of serious injury or even death is too great.
- Do not use the nipple from a baby bottle as a pacifier. If the baby sucks hard, the nipple may pop out of the ring and choke her.
- Pacifiers fall apart over time. Inspect them every once in a while to see whether the rubber has changed color or torn. If so, replace them.

## **Swaddling**

Babies can be swaddled as soon as they're born. It makes them feel cozy and warm, like they're "back home." All babies don't need to be swaddled. Many calm babies do well with no swaddling at all. But the fussier your baby is, the more she'll need to be swaddled. Tight bundling is so successful at soothing infants that some babies even have to be unswaddled to wake them up for feedings.

Swaddling should always be snug. Never put your baby into bed with loose blankets. Make sure her swaddling is snugly wrapped around her so it doesn't loosen during the night. Loose blankets can get around a baby's face and contribute to sudden infant death syndrome (SIDS). In traditional cultures, parents swaddle their babies tightly because loose wraps invariably pop open.

Although some Americans worry about tight swaddling, most of the time bundling fails because it is done too loosely. To make sure your wrapping is not too tight, slide your hand between the blanket and your baby's chest. It should feel as snug as your hand slid between your pregnant belly and the elastic waistband of your pants at the end of your ninth month.

Swaddling can help a baby sleep. Even babies who don't need wrapping to keep calm often sleep more when they're swaddled. Bundling keeps them from startling themselves awake. Swaddling plus white noise can add one to two hours to a baby's nighttime sleep.

The age for weaning off the wrapping varies from baby to baby. Many people think they should stop swaddling after a few weeks, when their baby starts resisting it. But, actually, this is when swaddling becomes the most valuable. To decide if your infant no longer needs to be wrapped, try this: After she reaches 2 to 3 months of age, swaddle her with one arm out. If she gets fussier, continue wrapping (with both arms in) for a few more weeks. However, if she still sleeps well with one arm out, she probably doesn't need swaddling any more. Most babies are ready to be weaned off wrapping by 3 to 4 months of age, although some continue to need the wrapping to help them sleep up to 9 months of age.

### **Proper Swaddling Technique**

There are as many ways to swaddle a baby as there are to fold a napkin for a dinner party, but the method outlined here is, in my opinion, the best. When learning to wrap, practice on a doll or on your baby when he (or she) is calm.

### **Prepare to start swaddling**



1. Place a large square blanket on your bed and position it like a diamond.
2. Fold the top corner down so the top point touches the center of the blanket.
3. Place your baby on the blanket so his neck lays on the top edge.
4. Hold your baby's right arm down straight at his side. If he resists, be patient. The arm will straighten after just a moment or two of gentle pressure.



1. **Down.** Just as swaddling is the cornerstone of calming, this first DOWN is the cornerstone of swaddling. It must be done well or the wrap will unravel. Hold your baby's right arm straight against his side, grab the blanket three to four inches from his right shoulder, and pull it *very snugly down* and across his body. (The blanket should look like half of a V-neck sweater.)
2. **Tuck.** Keeping the blanket *taut*, finish pulling it all the way down and *tuck* it under his left buttocks and lower back. This anchors the wrap.
3. **Snug.** While firmly holding the blanket against his left hip (with your left hand), grab the top edge of the blanket next to his unwrapped left shoulder and tug it *very, very snug*. Pull the blanket until there is absolutely no slack around your baby's right arm and the fabric is stretched to the max.



After this first "DOWN...tuck...snug," the baby's right arm should be held so securely against his side that he can't bend his arm up, even if you let go of the blanket. Don't be surprised or lose confidence if your baby suddenly cries louder when you pull the blanket tight. You're not hurting him!

**Up.** Now, straighten his left arm against his side and bring the bottom corner straight *up* to cover the arm. The bottom blanket point should reach up and over his left shoulder. It's okay if his legs are bent; that's how babies are positioned in the womb. But, be sure his arms are *straight*. If they're bent, he'll get out of the wrap as fast as you can say, "Oops, he did it again!" And, he'll cry even more.

1. **Tuck.** Tuck this corner tightly under his whole left arm with your right hand. Put your left hand on his straight left arm so it's pressed against his body.
2. **Snug.** While your left hand still holds his left arm down, use your right hand to grab the blanket three inches from his left shoulder and *snug* it with a *continuous* pull (stretch it as much as possible). This removes any slack next to his right arm.



1. **Down.** Still holding the blanket three inches from his left shoulder, pull the blanket taut and *down*, but only a smidgen.
2. **A smidgen.** This DOWN should bring only *a smidgen* of fabric over his left shoulder to his upper chest, like the second half of the V-neck sweater. (A mistake parents often make with the DUDU wrap is to bring this down fold all the way to their baby's feet.)

3. **Hold.** Using your left hand, *hold* that small fold of blanket pressed against his breastbone, like you are holding down a ribbon while making a bow.



1. **Up.** As your left hand holds that fold, grab the last free blanket corner with your right hand and pull it firmly, straight out to your right. This will get every last bit of stretch and slack out of the wrap you've done so far. And, without releasing the tension, lift that corner in one smooth motion, *up* and...
2. **Across.** Bring it tightly *across* his waist and wrap it around his body like a belt. The belt should go right over his *forearms*, holding them snugly down against his sides.
3. **Snug.** The finishing touch of the DUDU wrap is to *snug* the "belt" by giving it one last tight pull to remove any slack. Then tuck the end into the blanket as shown in the diagram. This last tight snug and tuck keeps the whole swaddle from popping open.

## BABY EQUIPMENT AND SUPPLIES

Before a baby is born, most parents prepare a special room. They fill it with clothing, a place to sleep, feeding equipment, bathing equipment, and diapers.

The most common mistake parents on a limited budget make during this time is the purchase of items they don't really need or expensive versions of essential pieces of equipment. Indeed, instead of buying everything you need, you may be able to borrow some baby equipment from friends or relatives.

Some baby equipment is essential, some is helpful but not essential, and some is unnecessary for most families. These three categories of equipment are described below.

### Essential Equipment

1. **Crib.** Your baby will spend much time in the crib unattended, so you must make certain it is a safe crib. Federal safety standards require that the crib bars of all cribs built after 1974 are no more than 2 and 3/8 inches apart. The purpose of this restriction is to prevent a child from getting his head or body stuck between the bars. If you have a crib built before 1974, check the distance between the bars. The width of 2 and 3/8 inches is approximately the width of three fingers. Do not buy or use a crib with spaces larger than this. Also check for any defective crib bars.

The mattress should be the same size as the crib so that your baby's head can't get caught in the gap. It should also be waterproof

During the first 2 or 3 months of life it may be more convenient for feeding during the night to have your baby sleep next to your bed in a bassinet. A basket with a firm pad on the bottom will also work.

**2. Bathtub.** You can buy small plastic bathtubs and molded sponge linings. A large plastic dishpan will also suffice. A kitchen sink works well if you are careful about preventing your child from falling against hard edges or turning on the hot water, thereby causing a burn.

**3. Bottles and nipples.** If you are feeding your baby formula, you will need about ten 8-ounce bottles. Although clear plastic bottles cost twice as much as glass ones, you will be glad you bought the unbreakable type the first time you or your baby drops one. If you use disposable bottle liners, you probably will need only five bottles.

You will also need 5 to 10 nipples. If you prepare more than one bottle at a time from concentrated formula, you will need a 1-quart measuring cup and a funnel for mixing a batch of formula. If you use powdered formula, the measuring cup is unnecessary.

**4. Diapers.** You can choose disposable or cloth diapers. The rate of diaper rashes is about the same with both kinds of diapers. If you're concerned about using diaper pins, worry not. Modern diaper covers come with Velcro straps. The main advantage of disposable diapers is that they are very convenient. They make family travel easier, and day care centers can operate more efficiently. The superabsorbent-gel diapers have the advantage of not letting urine leak out of the diaper. The main disadvantage of disposable diapers is that they cost more.

**5. Nasal suction bulb.** A rubber suction bulb is essential for helping young babies whose breathing has been made difficult by sticky or dried nasal secretions. A suction bulb with a blunt tip is more effective than a bulb with a long tapered tip and is less likely to irritate the nasal lining. (Bulbs with long tapered tips are used for irrigating ears.) The best suction bulbs on the market have a small clear plastic tip (a mucus trap) that can be removed from the bulb for cleaning.

**6. Thermometer.** A rectal thermometer is most helpful if your baby becomes sick. The digital thermometers that display the temperature in 30 seconds are worth the few extra dollars. If you buy a glass thermometer, the ones with four color zones are easier to read.

**7. Diaper and bottle bag.** For traveling outside the home with your baby, you will need an all-purpose backpack to carry the items that you need to feed your baby and change diapers. Packs often fit on the back of strollers. Backpacks are more comfortable and convenient than shoulder bags.

**8. Highchair.** During the first 6 months of life you can hold your baby whenever you feed him. However, you will need a highchair when your child can sit unsupported and is eating solid foods.

The most important feature of a high chair is a wide base that prevents the high chair from tipping. The tray needs to have a good safety latch. The tray should also have adjustable positions to adapt to your infant's growth. A safety strap is critical. Plastic or metal chairs are easier to clean than wooden chairs.

Small portable, hook-on highchairs that attach directly to the tabletop are gaining in popularity. They are convenient and reasonably priced. The ones with a special clamp that keeps your child from pushing the chair off the tabletop with his feet have a good safety record.

- 9. Training cup.** By the time your child is 1 year old, she will want to hold her own cup. Buy a spillproof one with a weighted base, a lid, and a spout. By 2 years of age, most children can use a regular cup.
- 10. Feeding spoons.** For feeding pureed foods and cereal while your baby's mouth is so small.
- 11. Safety gadgets.** Once your child is crawling, you will need safety gadgets such as electric-outlet safety plugs, cabinet door safety locks, bathtub spout protectors, toilet clamps, and plastic corner guards for sharp table edges.
- 12. Gates.** A gate is essential if your house has stairways that your baby must be protected from. A gate also helps keep a child in a specific room with you and out of the rest of the house (for example, when you are working in the kitchen). Many rooms can be closed off with doors. All gates should be difficult for a baby to climb. The strongest gates are spring-loaded.

## Helpful Equipment

Some of the following items provide your child with forms of transportation or special places to play. They all have some advantages. However, if none of them are available, you can carry your child whenever necessary and your child can play on a blanket on the floor.

- 1. Changing table.** Diapers need to be changed many times a day. You can use a bed to change your baby, but bending over the bed so many times a day may cause back strain. If you have a changing table you won't have to bend over every time you change your child. A regular table or buffet covered with a changing pad can work as well as a special baby-changing table.
- 2. Automatic swing.** Swings are entertaining to most babies. They are especially helpful for crying babies. They come in windup-spring, pendulum-driven, or battery-powered models. The mechanisms of the latter two types of swing are quieter than the first. Make sure a swing has a sturdy base and crossbars.
- 3. Front-carrier or sling.** Cloth carriers or slings that allow you to carry your new baby in front against your chest are great. They give your child a sense of physical contact and warmth. The slings are helpful during breast-feeding. They allow you freedom to use your hands. Buy one with head support. Carrying a baby in front after the age of 5 or 6 months can cause a backache for the parent.

- 4. Stroller.** Another way to transport a baby who has outgrown a front-carrier is a baby stroller. The most convenient strollers are the umbrella type, which fold up, and ones that have at least one reclining position. A safety belt is important to keep your baby from standing up in the stroller and falling out. A sunshade is also great for inspiring an afternoon snooze.
- 5. Infant seat, bouncer seat, or jumper.** An infant seat is a good place to keep a young baby when the baby is not eating or sleeping. A bouncer seat has the added advantage that your baby can make the seat move by him- or herself. Infants prefer this inclined position so they can see what is going on around them. Buy one with a safety strap, but don't substitute it for a car seat. After children are 3 to 4 months old they can usually tip the infant seat over, so stop using it when your baby reaches this age. They may enjoy a jumper seat as a substitution.
- 6. Playpen.** A playpen is a handy and safe place to leave your baby when you need uninterrupted time to cook a meal or do the wash. Babies like playpens because the slatted or mesh sides afford a good view of their environment. Playpens can be used both indoors and outdoors.
- As with cribs, the slats should be less than 2 and 3/8 inches apart. Playpens with a fine-weave netting are OK, although sometimes older infants can climb out of them. Bottomless playpens are gaining in popularity.
- Your baby should be introduced to the playpen by the age of 4 months so that she feels good about staying in it. It is very difficult to introduce a baby to a playpen after the baby has learned to crawl.
- Do not string any objects on a cord across the playpen. Your baby could become entangled in them and strangle.
- 7. Teething.** During teething, many infants like to chew on something. Teethingers are available in many shapes, sizes, and colors to help comfort and distract your baby.
- 8. Bib.** To keep food off your baby's clothes, find a molded plastic bib with an open scoop on the bottom to catch the mess.

## Unnecessary Equipment

Some baby equipment is usually not worth the investment, but your judgment may be different. You can bathe your baby without a special bathinette. Nursery monitors or intercoms will not prevent crib deaths and may interfere with your baby learning how to comfort himself. Baby carriages or buggies generally have been replaced by baby strollers, front-carriers, or backpacks. You can determine if your baby is being fed enough without a baby scale. You can prepare warm formula without a bottle warmer. Wipes don't need to be warmed in warmers. And shoes are not needed until your child has to walk outdoors.

An infant feeder is a bottle with a nipple on one end and a piston on the other. It is used to feed strained foods to young babies. Infant feeders are advertised as a "natural" step between bottle- and spoon-feeding. However, babies don't need any food other than formula or breast milk before they are at least 4 months old. When they are 4 months old, spoon-feeding works quite nicely.

Infant feeders are unnecessary and can lead to forced feedings.

Crib bumper pads are unnecessary because infants rarely strike their head on the railings. The pads have the disadvantage of keeping your baby from seeing out of the crib. Also, an older infant might climb on top of the pads and possibly fall from the crib.

## **Harmful Equipment: Walkers**

Over 40% of children who use walkers have an accident requiring medical attention. They get skull fractures, concussions, dental injuries, and deep cuts. There have even been some deaths. Most of the serious walker injuries occur from falling down a stairway. When a crawling child falls down steps, his tumbling breaks his fall. When a child goes down a stairway in a walker, he accelerates and crash-lands at the bottom.

Some parents believe walkers help children learn to walk. On the contrary, walkers can delay both crawling and walking if used over 2 hours a day.

Don't buy a walker. But if you have one, take the wheels off. If you're not convinced of the dangers and leave the wheels on, be sure to keep the door to any stairway locked. Children in walkers have crashed right through gates.

## **CAR SEAT SAFETY**

Every state requires that infants and children ride buckled up. However, state laws do not always require the safest way to transport a child. More children are still killed as passengers in car crashes than from any other type of injury. Using a car safety seat correctly can help prevent injuries to young children, but it is not as easy as you think. Just a little mistake in how the seat is used could cause serious injury to your child.

### **Which is the "best" car safety seat?**

- No one seat is safest" or best." The best" car safety seat is one that fits your child's size and weight, and can be installed correctly in your car.
- Price does not always make a difference. Higher prices can mean added features that may or may not make the seat easier to use.
- When you find a seat you like, try it out! Put your child in the seat and adjust the harnesses and buckles. Make sure it fits in your car.
- Keep in mind that displays or illustrations of seats in stores do not always show them being used correctly.

## **Types of Car Seats**

### **Infant-only seats**

- Only can be used rear-facing
- Are used for babies who weigh up to 20 pounds (or more, depending on the model)
- Are small and portable and fit newborns best
- Come with a 3-point harness or a 5 point harness

## Infant only seat features

- 1. Detachable base.** Several infant only seat models come with detachable bases. The base attaches to the car and the car safety seat easily snaps into the base. This way, you can carry your baby in and out of the car without needing to re-install the seat. After buckling your baby into the seat, you simply lock the seat into the installed base. Some bases are adjustable to make it easier to correctly recline newborns. These seats also can be used without the base or you can buy additional bases for other cars. However, this feature is only helpful if the base fits tightly into your car. In some cases, the seat may fit better without the base.
- 2. Higher weight and height limits.** Several infant-only seats are available for use up to 22 pounds, and at least one is available for use up to 35 pounds. Many convertible seats also now have higher weight and height limits in the rear-facing position for heavier or taller babies. Keep in mind that some babies may reach the top height limits of the seat before they reach the top weight limits. If your infant's weight or height exceeds the limits of the seat before a year, use an infant-only seat or a rear-facing convertible seat that has a higher limit.
- 3. Harness slots.** Infant-only seats that come with more than one harness slot give more room for growing babies. In the rear-facing position, the harness slots usually should be at or below your baby's shoulders. Check the car safety seat manufacturer's instructions to be sure.
- 4. Handles.** Carrying handles on car safety seats vary greatly in style and ease of use. Check the instructions for how to adjust the handle during travel.
- 5. Other features.** Angle indicators, built-in angle adjusters, harness adjusters, and head support systems are other features that may make correct installation easier to achieve.

## Convertible seats

- Are bigger and heavier than infant-only seats, but can be used longer and for larger children
- May not fit newborns as well as some infant-only seats. Make sure that your baby can recline comfortably in the seat. Check the car safety seat manufacturer's instructions to be sure that harnesses can be adjusted properly.
- Are used rear-facing for infants until they have reached at least 1 year of age and weigh at least 20 pounds (or more depending on model). The American Academy of Pediatrics (AAP) recommends that babies be kept in rear-facing seats until they reach the maximum weight allowed, as long as the top of the head is below the top of the seat back.
- Can be used forward-facing for toddlers who are at least 1 year of age *and* weigh at least 20 pounds and not more than 40 pounds. When your child is older than 1 year of age and has reached the highest weight or height allowed by the seat for use rear-facing, you may turn the seat forward-facing and make the following 3 adjustments:
  - Move the shoulder Straps to the slots at or above your child's shoulders (usually the top slots, but check your instructions to make sure).
  - Move the seat into the upright position. (Check the car safety seat manufacturer's instructions for the recline angle allowed when forward-facing.)
  - Route the seat belt through the forward-facing belt path.
- Have the following 3 types of harnesses:
  - **5-point harness**-5 straps: 2 at the shoulders, 2 at the hips, 1 at the crotch
  - **Overhead shield**-A padded tray-like shield that swings down around the child
  - **T-shield**-A padded T-shaped or triangular shield attached to shoulder straps

Note: If using a convertible seat for a small infant, the best choice for a more secure fit is the 5-point harness. A small baby's face can hit a shield in a crash.

Convertible seat features

- 1. Adjustable buckles and shields.** Many convertible seats have 2 or more buckle positions to give you extra room for a growing child or bulky clothing. Many overhead shields can be adjusted as well.
- 2. Higher weight limits.** Several convertible seats are now available with higher rear-facing weight limits for bigger babies. For larger babies, look for a seat that can be used rear facing up to 30 or 35 pounds.

#### **Combination seats**

- Cannot be used rear-facing.
- Are only for children who are at least 1 year of age and weigh at least 20 pounds.
- Have an internal harness system for children who weigh 40 pounds or less.
- Convert to belt-positioning boosters (by removing the harnesses) for children who weigh more than 40 pounds. This allows the seat to be used longer.

#### **Forward-facing seats/restraints**

- Cannot be used rear-facing
- Are only for children who are at least 1 year of age and weigh at least 20 pounds
- Can be used with lap only belt or lap/shoulder belt

Children who weigh 40 pounds or less are best protected in a seat with a full harness. Significant injuries have occurred to children in shield boosters in crashes due to ejection, excessive head movement, and shield contact. Although boosters with shields may meet current Federal Motor Vehicle Safety Standards for use by children who weigh 30-40 pounds, on the basis of current published peer-reviewed data, the AAP does not recommend their use. Children should remain in a convertible, forward-facing, or combination seat with a full harness until they reach the top weight or height allowed by the seat.

#### **Travel vests**

A travel vest may be an option if your car has only lap belts.

#### **Built-in seats (integrated seats)**

Built-in seats are available in some cars and vans. They may be used for children who are at least 1 year of age and weigh at least 20 pounds. Built-in seats eliminate installation problems. However, weight and height limits vary. Check with vehicle manufacturers for details about built-in seats that are currently available.

#### **Car seats and shopping carts**

Do not place a child of any age in a shopping cart. Many infant-only car seats lock into shopping carts. Although infant seats may help prevent falls from shopping carts, injuries can still occur if the cart tips over. The weight of an infant in an infant seat placed high in a shopping cart may make the cart more top-heavy and more likely to tip over. This is true even for shopping carts with built-in infant seats. Thousands of children are hurt every year from falling from shopping carts or from the carts tipping over. Instead, use a backpack, front pack, or stroller while shopping.

### **Basics of car safety seat use**

- Always use a car safety seat, starting with your baby's first ride home from the hospital. Help your child form a lifelong habit of buckling up.
- Read the car safety seat manufacturer's instructions and always keep them with the car safety seat.
- Read your vehicle owner's manual for important information on how to install the car safety seat correctly in your vehicle.
- The safest place for all children to ride is in the back seat.
- Never place a child in a rear-facing car safety seat in the front seat of a vehicle that has a passenger air bag.
- The harness system holds your child in the car safety seat and the seat belt or an anchor system holds the seat in the car. Attach both snugly to protect your child.

## **Using the Car Seat Safely**

Read the car safety seat manufacturer's instructions and the child restraint section of your vehicle owner's manual carefully to be sure you are installing and using the car safety seat correctly.

When you install the seat in your car, check the following:

### **Is your child buckled into the car safety seat correctly?**

- Be sure to use the correct harness slots for the child.
- Keep the harnesses snug. Place the plastic harness clip, if provided, at armpit level to hold shoulder straps in place.
- Make sure the straps lie flat and are not twisted.
- Dress your baby in clothes that allow the straps to go between the legs. Adjust the straps to allow for the thickness of your child's clothes, making sure that the harness still holds the child securely.
- In cold weather, tuck blankets around your baby after adjusting the harness straps snugly.
- To keep your newborn from slouching, pad the sides of the seat and between the crotch with rolled up diapers or receiving blankets.

### **Is the car safety seat buckled into your vehicle correctly?**

- Place the seat facing the correct direction for the size and age of your child. Route the seat belt through the correct path on the car safety seat (check your instructions to make sure) and pull it tight. Before each trip, check to make sure the car safety seat is installed tightly enough by pulling on the car safety seat where the seat belt passes through. It should not move easily side to side or toward the front of the car.
- If your infant's head flops forward, the seat may not be reclined enough. Tilt the seat back until it is reclined as close as possible to a 45-degree angle (according to manufacturer's instructions). Your seat may have a built-in recline adjuster for this purpose. If not, you may wedge firm padding, such as a rolled towel, under the front of the base of the seat.
- Check the seat belt buckle. Make sure it does not lie just at the point where the belt bends around the car safety seat. If it does, you will not be able to get the belt tight enough. If you cannot get the belt tight, check the car safety seat and vehicle manufacturer's instructions for recommendations. You may need to use another set of belts in the car that can be tightened properly.

- Many lap/shoulder belts allow passengers to move freely even when they are buckled. Read your car owner's manual to see if your seat belts can be locked into position or if you will need to use a locking clip. Locking clips come with all new car safety seats (some have them built in). Read your instructions for information on how to use the locking clip.
- Some lap belts need a special, heavy-duty locking clip, available from the vehicle manufacturer. Check your car owner's manual for more information.

**What is LATCH?** A new car safety seat attachment system has been developed to make car safety seats easier to use and safer. The system is called LATCH, which stands for Lower Anchors and Tethers for Children. This new anchor system will make correct installation much easier because you will no longer need to use seat belts to secure the car safety seat. Starting in model year 2002, most new vehicles and new safety seats will be equipped with these lower anchors and attachments. However, unless both the vehicle and the car safety seat have this new anchor system, seat belts will still be needed to secure the car safety seat.

**Why are tethers important?** Most new car safety seats that can be used facing forward come with top tethers. A tether is a strap that hooks the top of the car safety seat to a special permanent anchor in the vehicle. Most anchors are located on the rear window ledge, the back of the vehicle seat, or the floor or ceiling of the vehicle. Tethers give extra protection by keeping the car safety seat from being thrown forward in a crash.

Tether kits are available for most older car safety seats. Check with the car safety seat manufacturer to find out how to get a top tether for your seat. Be sure to install it according to instructions. The tether strap may help make some seats that are difficult to install fit more tightly.

All new cars, minivans, and light trucks have been required to have upper tether anchors for securing the tops of car safety seats since September 2000.

There are a number of add-on products on the market that claim to solve the problem of poorly fitting seat belts. However, these products may actually interfere with proper lap and shoulder belt fit by causing the lap belt to ride too high on the abdomen and making the shoulder belt too loose. Until the NHTSA develops standards for these products, the AAP recommends they not be used.

**Are you using a secondhand seat? Double-check everything!** A new car safety seat is best. However, if you must get a used seat, shop very carefully. Keep the following points in mind:

**Do not use a car safety seat that**

- **Is too old.** Look on the label for the date it was made. If it is more than 10 years old, it should not be used. Some manufacturers recommend that seats only be used for 5—6 years. Check with the manufacturer to find out when the company recommends getting a new seat.
- **Was in a crash.** It may have been weakened and should not be used, even if it looks fine. Do not use a seat if you do not know its full history.
- **Does not have a label with the date of manufacture and seat name or model number.** Without these, you cannot check on recalls.

- **Does not come with instructions.** You need them to know how to use the car safety seat. Do not rely on the former owner's directions. Get a copy of the instruction manual from the manufacturer before you use the seat.
- **Has any cracks in the frame of the seat.**
- **Is missing parts.** Used seats often come without important parts. Check with the manufacturer to make sure you can get the right parts.

### **Proper installation**

For specific information about installing your car safety seat, you may consult a certified Child Passenger Safety (CPS) Technician. The American Automobile Association (AAA) certifies CPS Technicians. A list of certified CPS Technicians is available by state or ZIP code on the NHTSA Web site at <http://www.nhtsa.dot.gov/CPS/Contacts/index.cfm>

A list of inspection stations staffed by certified CPS Technicians is available at <http://www.nhtsa.dot.gov/nhtsa/whatis/regions/index.cfm>

The information is available by telephone on the NHTSA Auto Safety Hot Line at 888/DASH-2-DOT (888/321-4236), from 8am to 10pm ET Monday through Friday.

A new toll-free number and Web site sponsored by an automobile manufacturer and supported by the National Highway Traffic Safety Administration (NHTSA) allows consumers to locate the nearest seat Inspection facility for hands-on assistance: (866) SEAT-CHECK, or (866) 7328-24325, and <http://www.seatcheck.org>.

**Has the car safety seat been recalled?** You can find out by calling the manufacturer or the Auto Safety Hot Line at 888/DASH-2-DOT (888/327-4236), from 8 am to 10 PM ET, Monday through Friday. This information is also available on the NHTSA Web site at <http://www.nhtsa.dot.gov/cars/problems/recalls/index.cfm>. If the seat has been recalled, be sure to follow instructions to fix it or get the necessary pads. You also may get a registration card for future recall notices from the hot line.

## **Common Questions about Car Safety Seats**

**What if my baby is premature?** Use a car safety seat without a shield. Shields often are too high and too far from the body to fit correctly. A small baby's face could hit a shield in a crash. While still in the hospital, your baby should be observed in her car safety seat to make sure that the semi-reclined position does not cause low heart rate, low oxygen, or other breathing problems. If your baby needs to lie flat during travel, use a crash-tested car bed. If possible, an adult should ride in the back seat next to your baby to watch him closely.

**What if my baby weighs more than 20 pounds but is not 1 year of age yet?** There are now several infant-only and convertible seats that can be used rear-facing for children weighing more than 20 pounds.

**What if my baby is longer than the rear-facing height limits and not yet 1 year of age?** Keep your child rear facing until his head is one inch from the top of the seat.

**What if my car only has lap belts in the back seat?** Lap belts work fine with infant-only, convertible, and forward-facing seats. They cannot be used with belt-positioning boosters (which are safest for children who weigh more than 40 pounds and who are not big enough to fit in adult seat belts). If your car only has lap belts, use a forward-facing seat with a harness approved for use to higher weights, use a forward-facing restraint, or check with your dealer or the manufacturer of your car to see if shoulder harnesses can be installed. Some travel vests can be used with lap belts. Another thing you can do is buy another car with lap/shoulder belts in the back seat.

**What if I drive more children than can be buckled safely in the back seat?** Avoid this situation, especially if your car has passenger air bags. However, in an emergency, place the child most likely to sit in the proper forward-facing position in the front seat, with the vehicle seat moved as far back as possible. A child in a forward-facing car safety seat may be the best choice because a child who is in a booster seat or using a regular seat belt can more easily move out of position and be at greater risk for injuries from the air bag.

**What if I lose my instructions to my car safety seat?** If you do not have the car safety seat manufacturer's instructions, write or call the company's consumer relations department, identifying the model number, name of seat, and date of manufacture. The manufacturer's address and phone number may be on the label on the seat.

**What if my car safety seat was in a crash?** A seat that was in a crash may have been weakened and should not be used even if it looks fine. Call the car safety seat manufacturer if you have questions about the safety of your seat.

**Can I use a car safety seat on an airplane?** The Federal Aviation Administration (FAA) and the AAP recommend that children be securely fastened in child safety seats until 4 years of age, then be secured with the airplane seat belts. This will help keep them safe during takeoff and landing, or in case of turbulence. Most infant, convertible, and forward-facing seats are certified for use on airplanes. Booster seats and travel vests are not. Check the label on your seat and call the airline before you travel to be sure your seat meets current FM regulations.

**Always Read and follow the Manufacturer's Recommendations**

## **One-Minute Car Seat Safety Check**

Using a car seat correctly makes a big difference. Even the "safest" seat may not protect your child in a crash unless it is used correctly. So take a minute to check to be sure...

### **Does your car have a passenger air bag?**

- An infant in a rear-facing seat should NEVER be placed in the front seat of a vehicle that has a passenger air bag.
- The safest place for all children to ride is in the back seat.
- If an older child must ride in the front seat, move the vehicle seat as far back from the air bag as possible and buckle the child properly.

**Is your child facing the right way for both weight and age?**

- Infants should ride facing the back of the car until they have reached at least 1 year of age **AND** weigh at least 20 pounds.
- A child who weighs over 20 pounds **AND** is older than 1 year of age may face forward. However, it is safest for a child to ride rear-facing until she reaches the height and weight limit of the seat.
- A child who weighs 20 pounds before he reaches 1 year of age should ride rear-facing in a convertible seat approved for use at higher weights.

**Have you tried the car seat in your vehicle?**

- Not all car seats fit in all vehicles.
- When the car seat is installed, be sure it does not move side-to-side or toward the front of the car.
- Be sure to read the section on car seats in the owner's manual for your car.

**Is the seat belt in the right place and pulled tight?**

- Route the seat belt through the correct path (check your instructions to make sure), kneel in the seat to press it down, and pull the belt *tight*.
- A convertible seat has two different belt paths, one for infants and one for toddlers.
- Check the owner's manual for your car to see if you need to use a locking clip and read the car seat instructions to see if you need a tether to keep the safety seat secure.

**Is the harness snug; does it stay on your child's shoulders?**

- The shoulder straps of the car seat usually go in the lowest slots for infants riding backward and in the highest slots for children facing forward. (Check the car seat manufacturer's instructions to be sure.)
- The chest clip should be placed at armpit level to keep the harness straps on the shoulders.
- Harnesses should fit snugly against your child's body. Check the instructions on how to adjust the straps.

**Do you have the instructions for the car seat?**

- Follow them and keep them with the car seat. You will need them as your child gets bigger.
- Be sure to send in the registration card that comes with the car seat. It will be important in case your car seat is recalled.

**Has your child's car seat been recalled?**

- Call the Auto Safety Hotline for a list of recalled seats that need repair.
- Be sure to make any necessary repairs to your car seat.

**Has your child's car seat been in a crash?**

- If so, it may have been weakened and should not be used, even if it looks all right.
- Call the car seat manufacturer if you have questions about the safety of your seat.

**Is your car seat more than 6 years old?**

- If so it should be discarded and replaced with a new model

## Air Bag Safety

**An air bag can save your life. However, air bags and young children do not mix. The following information will help keep you and your children safe.**

- The safest place for all infants and children under 12 years of age to ride is in the back seat.
- *Never* put an infant under 1 year of age in the front seat of a car with an air bag.
- Infants must always ride in rear-facing car seats in the back seat until they are at least 20 pounds AND 1 year of age.
- All children should be properly secured in car safety seats, booster seats, or shoulder/lap belts correct for their size.
- Seat belts must be worn correctly at all times by all passengers to provide the best protection.

### What Parents Can Do

- Eliminate potential risks of air bags to children by buckling them in the backseat for every ride.
- Plan ahead so that you do not have to drive with more children than can be safely restrained in the backseat.
- 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, 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 properly buckled. 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.

## EARLY PARENTHOOD

If you are already a parent, you know that having your first baby qualifies as a life crisis. Most parents-to-be focus on the birth of their child. It is only after the birth that you begin to realize that the birth was just the beginning and the shock begins to set in.

Taking steps to prepare for the shock of parenting can help enormously. Mental and emotional preparation is just as important as preparing the nursery.

## Fatigue

Delivering a baby has been compared to running a marathon. Combine that with the change in sleep habits that night feedings require and you can understand why new mothers are exhausted. Anxiety over being a new parent adds to the fatigue.

### Hints for fatigue:

- Expect to be tired, and don't be upset with yourself about it.
- Nap when the baby naps.

- Try to sleep at least 1 and 1/2 or 2 hours during the day for the first 2 to 3 weeks. Ask your husband, a friend, or relative to take care of the baby during this time.
- You may want to nurse the baby in bed during night feedings.
- If you are bottle-feeding, share night feedings with your spouse.

## **Pain from a Cesarean Section**

Cesarean birth complicates the healing process and requires more rest and recuperation.

Hints for recovering from a cesarean birth:

- Use the time in the hospital to rest. You may need to control the number of phone calls and visitors.
- Make sure there is some kind of help available when you come home for at least the first 2 weeks. The more rest you get during that time, the faster you will heal.
- Until your incision heals, make sure you lift your baby slowly, keeping your arms close to your body, so that you put minimal strain on your stomach muscles.

## **Pain from an Episiotomy**

An episiotomy is an incision often made during birth to give more room for the baby to pass through the birth canal. It usually heals within 7 to 10 days and with no complications.

**Hints for recovering from an episiotomy:**

- Warm sitz baths and heat lamps (at a safe distance) can provide some comfort.
- You can prevent some of the pain by tightening your buttocks before you sit down. The hospital might be able to provide you with a plastic “doughnut” for you to sit on.
- Avoid straining when you have a bowel movement.
- Tucks pads can be used as a panty liner.

## **Emotions of a New Mother**

The emotions surrounding giving birth to a new human being are extremely strong, ranging from joy to panic and despair. In addition to these emotions, the birth process itself releases a flood of hormones in the mother’s body which often wreak havoc with her emotions.

**Hints for Dealing with Emotions of Becoming a Mother:**

- While it is easier said than done, try to prepare for the emotional effects of stress and lack of sleep--at the least make a pact with your spouse that all crying, shouting, and yelling during the first 3 months will be treated as material for stories of “how we fell apart while learning to be parents” and will be otherwise forgotten.
- Don’t try to be supermom. Some days, caring for your baby is all that you will get done.
- Take time for yourself without your baby. Hire a sitter, leave your baby with a close friend or your spouse, and get out.
- Reading is a cheap and easy way to escape.
- Keep yourself physically fit.

- Enjoy your baby! Rather than fight it, concentrate your energy and attention on nurturing that new member of your family. You can rest assured that you will soon have space for other goals in your life.
- Spend time with support groups and friends, and don't be afraid to share both your fears and your joys.
- Realize that adjustment to life as a new parent comes slowly. Have faith: millions of parents before you have managed to get their lives under control after the arrival of a new baby. You will manage quite well, too.

## **Baby Blues and Post Partum Depression**

Having a baby is a joyous time for most women, After childbirth, though, many mothers feel, sad, angry, afraid or anxious. Most new moms have these feelings in a mild form called postpartum blues. About 10-15 percent of new moms have a greater problem called postpartum depression. Postpartum depression lasts longer and is more intense. It often requires counseling and treatment.

### **Beating the “Baby Blues”**

The “Baby Blues” are normal for 80-90 percent of all new mothers and usually occur from day two to two weeks after delivery. These mood swings are caused by hormonal shifts in your body. Stress brought on by recent life changes and lack of sleep may also have an effect. The “blues” may last just a few days or weeks.

If you feel “blue” remember to try some of those activities that usually make you feel better. Get a friend or relative to help out with the baby so you can go for a walk or visit a friend just to chat. Sometimes just getting out of the house, even for a short time, can give you renewed energy and lift your spirits.

If you have tried some of these measures and still feel “blue,” you may want to call your health care provider for extra help and support.

### **Post Partum Depression – When to Get Help**

Post Partum Depression can occur anytime within the first year after giving birth. An estimated 10-15% of moms will get PPD. For these moms it is important to seek help quickly -- the faster the treatment, the faster the cure. Please call your health care provider and seek help if you have any of the following concerns:

- You don't want to be with your baby or lack the motivation to care for your baby
- You are afraid of being left alone with your baby
- You experience feelings of sadness, doubt, guilt or helplessness that seem to increase with time.
- You have no interest or an over interest in eating.
- You are extremely anxious or irritable.
- You are unable to sleep when the baby sleeps – regardless of how tired you are.
- You are afraid you may harm yourself and/or the baby.

## **Isolation**

After 3 months of taking care of a new baby, most new mothers feel lonely and isolated. If you are feeling isolated:

- Recognize that almost every mother has some feeling of being trapped about this time and also wonders if the rest of her life is going to be a routine of bottles, dirty diapers, and lack of sleep.
- You may want to join a parenting support group; it helps to share with other parents.
- It is important to find friends who also have small children. Playgroups for babies are a good place to meet other mothers.
- Your new baby will probably be a source of new interests: your concern for proper infant stimulation and development may prompt you to learn more about developmental psychology and human development; you may learn much more about music as you begin to expose your new baby to the world of music.

## **Relationship with your Spouse**

Like other forms of stress, the stress of parenting can both build and destroy your relationship with your spouse. As in other areas of parenting, open and caring communication is critical.

## **Parenting Roles**

In earlier times, the roles of father and mother were much more clearly defined than now: the father worked as the breadwinner and the woman stayed home and raised the children. These roles are no longer clear-cut for many families, which can result in conflict and stress for everyone involved unless the problem is resolved. Most families need to spend time discussing each member's role, making sure that everyone is comfortable with the situation. You should also recognize that this discussion has to continue, since your roles will shift as the demands of being a parent change.

New fathers come under stress in a number of ways. Many men feel a heavy burden of responsibility, and feel that they must now succeed financially. They often spend more time with work, just at the time when the woman wants them to spend extra time at home helping with the baby and providing some adult companionship. A new father also often feels cut out as his spouse's attention shifts to the new baby.

### **Hints for fathers:**

- While it is important to communicate your feelings to your wife, it is equally important to choose a proper time, place, and method: do not expect much attention and support from your wife when your baby has been crying for 2 hours. See if you can schedule time to talk: perhaps in the morning or after the baby has gone to sleep.
- Schedule a regular lunch or breakfast date with your wife when you can drop the baby off with a friend, grandparents, or a sitter.

- Many men panic about finances when a baby is born and begin to work longer and harder at their jobs. Unless you share these feelings with your wife, she is likely to perceive your longer work hours as escaping from the burden of caring for the new baby, not as trying to increase the family's financial security. Result: misunderstandings and fights.
- Most men feel awkward about handling a new baby. There is no substitute for hands-on experience--get involved from the beginning in all aspects of your baby's care. Try infant massage: it can be a good way to establish a nurturing, intimate relationship with your baby.
- Be an advocate for your wife if she decides to breast-feed. She will need your support and encouragement through the first 6 weeks of establishing a breast-feeding routine with the baby.
- It is enormously important that you tell your wife how much you appreciate all the effort she is making for the baby. New mothers often feel totally unappreciated.
- Maintain a sense of humor (easier said than done) and keep in mind that the first 3 months are the hardest time.

#### **Hints for mothers:**

- Recognize that most new mothers feel inadequate to deal with the demands placed on them.
- Communicate your feelings with your husband so that he knows how you are feeling, and try to do it when you have time to talk.
- Encourage your husband to help with the baby, and realize that the best way to turn him off is to criticize his technique of childcare.
- Be sure that you tell your husband how much his support means to you and thank him for his help.
- Save some time for your relationship with your husband--it doesn't have to be much.
- Maintain your sense of humor. Having a new baby has a lot in common with camping: at times all you can do is laugh and keep going!

## **SIBLING RELATIONSHIPS**

### **Preparing your Children for a New Baby**

A new baby brings both joys and challenges to a family. Parents are excited but they are also nervous about how their older children will react to the newborn. All sorts of questions come up: how should we tell our older children that they are going to have a baby brother or sister? Will they be jealous of the new baby? How can we make sure they will get along as they get older?

How your children react to a new baby depends largely on their ages at the time the baby is born. Knowing what to expect from each age group will make it easier to handle the changes in your family.

#### **Ages 2 to 4**

Toddlers and preschoolers may have a hard time adjusting to a new baby, especially if they are between 2 and 3 years old. At this age, your child is still very attached to you and does not yet understand about sharing you with others. Your child also may be very sensitive to changes going on around her, and may feel threatened by the idea of a new family member. Here are some suggestions for how to ease your preschooler into being a big brother or big sister

- **Wait a while before telling your preschooler that you are going to have a baby, but do not wait too long.** A child younger than 4 will have a hard time understanding an abstract concept like an unborn baby. You should explain it to your child when you start buying nursery furniture or baby clothes, or when she starts to ask about mom's growing 'stomach.'" Picture books for preschoolers can be very helpful. So can sibling preparation classes (ask your hospital if they offer them). Try to tell your child before she hears about the new baby from someone else.
- **Be honest.** Do not promise that things will be the same after the baby comes, because they will not be, no matter how hard you try. Explain that the baby will be cute and cuddly, but will also cry and take a lot of your time and attention. Also, make sure that your older child knows that the baby will not be an instant playmate. Let your preschooler know that you will love her just as much after the baby is born as you do now
- **Involve your preschooler in planning for the baby.** This will make her less jealous. Let her shop with you for baby items. Show her pictures of herself as a newborn, If you are going to use some of her old baby things, let her play with them a bit before you get them ready for the new baby.
- **Do not make major changes in your preschooler's routine until after the baby is born.** You should complete making any changes such as toilet training or switching from a crib to a bed before the baby arrives. If that is not possible put them off until after the baby is settled in at home. Otherwise, your preschooler may feel overwhelmed by trying to learn new things on top of all the changes caused by the new baby.
- **Expect your child to "regress" a little.** Do not worry too much if news that a baby is coming or if the baby's arrival makes your preschooler start acting like a baby again. For example, your toilet-trained child might suddenly start having 'accidents,' or she might want to take a bottle. This is normal and is your older child's way of making sure she still has your love and attention. Instead of telling her to act her age, let her have the attention she needs. Praise her when she acts more "grown-up."
- **Prepare your child for when you are in the hospital.** Toddlers and preschoolers may be confused when you leave for the hospital. Explain to your child that you will be back with the new baby in a few days.
- **Set aside some special time for your older child.** No matter how busy you are with the new baby, make sure you save some special time each day just for you and your older child. Read, play games, listen to music, or simply talk together. Show her that you want to know what she is doing, thinking, and feeling—not only about the baby but about everything else in her life. Make her feel a part of things by having her cuddle next to you when you feed the baby.
- **Encourage visitors to give attention to your older child.** Visitors can make such a fuss over a new baby that your older child might feel left out. Ask family and friends to spend a little time with your older child when they come to see the new baby. They might also give her a small gift when they bring gifts for the baby.
- **Have your older child spend time with dad.** A new baby presents a great opportunity for fathers to spend time alone with older children.

### **School-age children**

Children older than 5 are usually not as threatened by a newborn as younger children are. This is particularly true if the school-age child has good self-esteem and feels loved and valued. Even so, your older child may resent the attention the baby gets. To prepare your school-age child for a new baby:

- **Tell your child about what is happening in language she can understand.** Explain what having a new brother or sister means, noting that the changes may affect her both the good and the not-so-good.
- **Make your firstborn feel like a part of the process.** Have your older child help get the house ready for the new sibling by fixing up the baby's bedroom, picking out a new crib, buying diapers. If there is time, have her come to the hospital soon after the delivery so that she feels part of the growing family. Then, when you bring the baby home, make your older child feel that she has a role to play in caring for the baby. Tell her she can hold the baby, although she must ask you first. Praise her when she is gentle and loving toward the baby.
- **Make sure your older child feels listened to.** Do not overlook your older child's needs and activities. Let her know she can talk about her feelings. Tell her: 'A new baby means a lot more work for me. If you ever feel that I am not spending enough time with you, let me know so I can give you plenty of extra love.' Make an effort to spend some time alone with her each day; use that as a chance to make her feel like the most important person in your life.

### **What parents can do about sibling rivalry?**

It is important not to get too upset when your children are jealous of each other, especially if the older child is a preschooler. It takes time for a youngster to learn that his parents do not love him any less because they have another child to love.

Here are some tips on managing conflict between your children

- **If your older child starts imitating the baby, do not make fun of or punish him.** Let him drink from a bottle or climb in the crib once or twice, but make it very clear that he does not have to act like a baby to get your attention. Praise him when he acts grown up" and give him chances to be a big brother." It should not take long for him to see that he gets more attention by acting his age than by acting like a baby.
- **If your older child is between 3 and 5 years old, try to cut down on conflicts over space by setting aside an area just for her.** Giving your older child her own space and keeping her things apart from shared ones will cut down on quarrels.
- **Do not compare your children in front of them.** It is natural to notice differences between your children. Just try not to comment on these in front of them. It is easy for a child to think that he is not as good or as loved as his sibling when you compare them. Remember that each child is a special individual. Let each one know that.

Sibling relationships are very special. We form our earliest bonds with our brothers and sisters. No one else shares the same family history. By helping your children learn to value, love and respect their siblings, you are giving them a great gift—the gift of a lifelong friend.

## **INFANTS' ENVIRONMENT**

### **Going Outside**

Fresh air and a change of surroundings are good for both you and your baby, even in her first month, so take her out for walks when the weather is nice. Be careful to dress her properly for these outings, however. Her internal temperature control isn't fully mature until the end of her first year. This makes it difficult for her to regulate her body temperature when she's exposed to excessive heat or cold. Her clothing must do some of this work by keeping heat in when she is in a cold location and letting heat escape when in a warm place. In general, she should wear one more layer than you do.

Your infant's skin also is extremely susceptible to sunburn during the first six months, so it's important to keep her out of direct and reflected sunlight (off of water, sand, or concrete, for example) as much as possible. If you must take her out in the sun, dress her in lightweight and light-colored clothing, with a bonnet or hat to shade her face. If she is lying or sitting in one place, make sure it is shady, and adjust her position to keep her in the shade as the sun moves. Sunblock is not recommended for infants under six months of age.

Another warning for the hot-weather months: Do not let baby equipment (car seats, strollers) sit in the sun for a long period of time. When that happens, the plastic and metal parts can get hot enough to burn your child. Check the temperature of the surface of any such equipment before you allow your baby to come in contact with it.

To check whether she's clothed well enough, feel her hands and feet and the skin on her chest. Her hands and feet should be slightly cooler than her body, but not cold. Her chest should feel warm. If hands, feet, and chest feel cold, take her to a warm room, unwrap her, and feed her something warm or hold her close so the heat from your body warms her. Until her temperature is back to normal, extra layers of clothing will just trap the cold, so use these other methods to warm her body before wrapping her in additional blankets or clothing.

## **Visitors**

It's not a problem to have close friends and family hold your newborn, as long as they wash their hands first and avoid coughing or sneezing near him. Also, try not to let too many people handle him for too long. Newborns aren't necessarily more susceptible than adults to whatever bugs might be going around but they do suffer more severe illnesses when they catch routine infections. Also they are prone to over stimulation when exposed to too much handling and noise. Once they're more than a month or two old, you won't need to be so vigilant about protecting them from visitors.

## **Temperature**

The best temperature for your home is a comfortable one (68-72 degrees). But, it definitely takes practice to be able to tell when your baby is too hot or too cold. In the early months of life, most babies have difficulty maintaining the appropriate body temperature. Because babies can easily become too hot or cold, you'll need to help them stay comfortable by using the following guidelines: If your baby is sleeping comfortably and feeding well, and is calm and not too cranky, then she's probably the appropriate temperature. You can also check to make sure that her extremities — her hands, feet, and head — are neither hot nor cold to the touch.

## **Tobacco Smoke**

Smoking is the leading cause of preventable death in the United States. People who are around smokers can't help breathing in the smoke that comes from cigarettes, pipes, or cigars. Researchers have now found that breathing in someone else's smoke is very dangerous, especially for children. The American Academy of Pediatrics offers parents the followings information to help them create a tobacco-free environment" for their children.

**What is Environmental Tobacco Smoke (ETS)?** Environmental Tobacco Smoke, or ETS, is the smoke that is breathed out by a smoker. ETS also includes the smoke that comes from the tip of a burning cigarette. Exposure to ETS happens any time someone breathes in the smoke that comes from a cigarette, pipe, or cigar. ETS contains many dangerous chemicals that have been proven to cause cancer. It is estimated that ETS causes 3,000 lung cancer deaths each year to people who don't even smoke!

**ETS and children.** ETS has almost 4,000 chemicals in it that infants and children breathe in whenever someone smokes around them. Children who breathe in ETS are at risk for many serious health problems.

When a mother smokes during pregnancy, she has a higher risk of having a premature baby or a baby who is not fully developed. When a mother smokes during her pregnancy or around her newborn, the infant has a higher risk of Sudden Infant Death Syndrome (SIDS). Children who breathe in someone else's cigarette smoke (especially children under 2 years of age) have a higher risk of getting other serious medical problems or making them worse, including the following:

- Ear infections and hearing problems
- Upper respiratory infections
- Respiratory problems such as bronchitis and pneumonia
- Asthma

Children of smokers also cough and wheeze more and have a harder time getting over colds. In addition, ETS can cause a stuffy nose, headaches, sore throat, eye irritation, hoarseness, dizziness, nausea, loss of appetite, lack of energy, or fussiness.

Children with asthma are especially sensitive to ETS. ETS can actually increase the number and severity of asthma attacks, which may require trips to the hospital. Also, exposure to the smoke of as few as 10 cigarettes per day raises a child's chances of getting asthma even if that child has never had any symptoms.

With all of these dangers, it's easy to understand why children should not be exposed to ETS.

Inhaling the smoke from the cigarettes of others is dangerous for pregnant women, too. Pregnant women should stay away from smoking areas and ask smokers not to smoke around them.

**Smoking During Pregnancy.** When a woman smokes during her pregnancy, her unborn child is exposed to the chemicals in the smoke. This can be very harmful to the child and can lead to many serious health problems including:

- Miscarriage
- Prematurity (having a baby that is not fully developed)
- Low birth weight therefore a less healthy baby

These risks go up the longer a mother smokes and the more cigarettes she smokes during her pregnancy. Quitting anytime during the pregnancy will help—of course, the sooner the better.

**How parents can protect their children from ETS.** If you are a smoker—quit! It’s one of the most important things you can do for the health of your children and the best way to prevent your child from being exposed to ETS. If you are having trouble quitting smoking, ask your doctor for help. Also, contact your local chapter of the American Lung Association, American Heart Association, the American Cancer Society, or other groups that sponsor stop-smoking classes.

As a parent, you are a role model. Children watch what their parents do. If your child sees you smoking, he or she may want to try smoking and grow up to become a smoker as well. Cigarette smoking by children and adolescents causes the same health problems that affect adults.

**How do you avoid being around smokers?** One way is to ask people not to smoke around your children or remove your child from places where there are smokers. The following tips may help you keep your children from being exposed to ETS:

- Don’t let people smoke in your house. Don’t put out any ashtrays—this will discourage people from lighting up. Remember, air flows throughout a house, so smoking in even one room allows smoke to go everywhere.
- Don’t let people smoke in your car. Opening windows is not enough to clear the air.
- Choose a babysitter who doesn’t allow smoking in the house.
- Avoid crowded smoky restaurants when you are with your child.
- When you are with your child in public places—shopping malls, restaurants, bowling alleys—sit in “nonsmoking” sections.

Almost 50% of the homes in the United States have at least one smoker living there. This means that millions of children in the United States are breathing in ETS in their own homes. If you smoke around your child or allow your child to be exposed to ETS in other places, you may be putting him or her into more danger than you realize.

Parents need to make every effort to keep their children away from smokers and ETS. Parents who smoke should think about quitting, not just for their own sake, but for the health of their children.

**Smoking and Children—A Fire Hazard.** In addition to the dangers of ETS, smoking around children can also pose fire and burn dangers. Children can get burned if they play with lit cigarettes, cigars, or with lighters or matches. Keep the following guidelines in mind to keep your child safe from injury:

- Never smoke while you are holding your baby.
- Never leave a lit cigarette, cigar, or pipe unattended.
- Keep matches and lighters out of your child’s reach.

Cigarette lighters are especially dangerous. Cigarette lighters can be found in almost 30 million homes in the United States. Each year children under 5 years old playing with lighters cause more than 5000 home fires resulting in about 130 deaths and more than 1,000 injuries. The Consumer Product Safety Commission (CPSC) now requires that butane cigarette lighters be made child-resistant. This new rule will prevent hundreds of deaths and fire-related injuries to children each year. But remember lighters can be made child-resistant, not childproof. It is still very important to keep lighters and matches away from children.

# WORKING OUTSIDE THE HOME

## The Decision to Work

- 1. Reasons for working.** More than 50 percent of mothers with infants or preschoolers work outside the home. Some mothers are working financial need. Some mothers return to work because they enjoy it or need to stay up-to-date in a fast-changing career.

The question of returning to work versus staying at home has no easy or correct answer. The decision is one that each mother must make based on her particular circumstances. Children can do well either way. The family's needs and financial security are the real considerations.

- 2. Pros and cons for your child.** If you provide your child with a consistent nurturing caretaker, there is no reason that your return to work will cause your child any harm. Children whose mothers work outside the home develop as well emotionally as do other children. The mother-child bond is not weakened. Benefits for a child whose mother works outside the home include increased independence, responsibility, and maturity. Young children of working mothers often have more opportunities to learn to trust other adults and to negotiate better with peers.

- 3. Timing the return to work.** A mother needs 6 to 8 weeks at home after the birth of her baby to recover physically from childbirth and establish breast-feeding. A preferred maternity leave would extend to 4 months after the birth, at which time the mother will have developed greater confidence in her mothering skills. In addition, by 4 months, the baby should have formed a secure attachment to his mother and be sleeping through the night. Some authorities suggest that mothers should try to spend the first 2 or 3 years of their baby's life fully involved with child rearing, but the advantages of this commitment remain unproven. Unfortunately, many mothers do not have the luxury of deciding when they will return to work. Mothers should not feel guilty about returning to work.

## Choosing the Right Caregiver

### Types of child care

Caregivers can be family members, close friends, or trusted employees. You can choose from three types of care:

- **In-home care** services bring the caregiver into your home.
- **Family childcare** is offered in the home of the caregiver.
- **Center-based care** usually takes place outside the home in a facility designed for young children. You should consider the pros and cons of each type of care.

**In-home care** can be very convenient. Many home care providers can arrange their schedules to match your needs. Since the caregiver comes to your home, your child does not have to adjust to a new setting. This gives you greater control over your child's environment. Also, your child can receive more individual attention, especially if the caregiver is not expected to do housekeeping. Home care may lessen your child's exposure to seasonal illnesses, because of exposure to fewer children.

Skilled in-home providers are difficult to find. You will need a backup plan for the times when the caregiver is sick or goes on vacation. You alone are the judge of the caregiver's character, health, and skill. It is hard to know for sure what the caregiver does when you are not there. In some urban areas, agencies may provide training, placement, and supervision for in-home providers.

The training of home care providers should include emergency response to choking and first aid. The caregiver should provide you with a daily schedule and a daily report. Plan frequent opportunities for someone to observe the caregiver's interactions with your child.

**Family childcare** takes place in the caregiver's home. Many family child care providers who offer child care have young children of their own. Caregivers may care for children who are the same age or for children of all ages.

Check to see that the home is clean and safe. Also, make sure that the caregiver and the caregiver's children are healthy. Television watching should be limited to 1 or 2 hours per day. Carefully review how the caregiver handles meals and discipline.

Including the caregiver's own children, a childcare home should not have more than six children per adult caregiver. (In some states, group homes allow more children when at least two adults are available at all times.) The total number of children should be less when infants and toddlers are included. Unlike child care center recommendations, a single caregiver within the family care setting should care for no more than two children younger than 2 years of age. Since there is only one adult, backup care in an emergency situation must be close by. In some areas, caregivers belong to a network of family childcare providers who may provide backup help.

Family childcare providers usually work alone. This makes it hard to judge their work. Look for caregivers who are licensed or registered with the state and have their home visited by an inspector. Family caregivers can be accredited through the National Association for Family Child Care (NAFCC).

**Center-based care** has many names—childcare center, preschool, nursery school, or learning center. Center-based care also may have different sponsors, including churches, schools, colleges, universities, social service agencies, Head Start, independent owners and chains, and employers. Regardless of what type of child care center you choose, there are some basic things to consider:

- All centers should be licensed and inspected regularly for health, safety, cleanliness, staffing, and program content. Just because a center is licensed, do not assume it is regularly inspected. Check to see how often the center you are considering had announced and unannounced inspections in the past year and what was checked. To find out about the regulations in your area, contact your city, county, or state department of social services.
- Caregivers and center directors should have basic training and experience in early childhood development. Check to see if state or national organizations accredit the center. Several independent groups of early childhood care and education professionals offer accreditation. For centers, these are the National Association for the Education of Young Children (NAEYC) or the National Child Care Association (NCCA). (Although it is reassuring to know that a caregiver is accredited, some very good care-givers may not be accredited by either of these organizations. You might suggest that they apply for accreditation.)

- Look for age-appropriate toys, a daily schedule that is used, and joyful interactions between children and staff. Parents should be able to make unannounced visits to the center to see their child, and receive quick notification if their child gets sick or is injured.
- Be sure to check the center's special programs and published policies, including its policies on sick children. Centers have the advantage of covering a caregiver's illness or vacation.
- Look for centers that have two caregivers per room, a window or glass door for supervisors to view activities, and ongoing staff training.

Paying for childcare can be quite an investment, so families must budget ahead. Although the cost seems high, consider how much the caregiver should earn for professionally meeting your family's childcare needs and helping your child develop normally. Ask your company for assistance from:

- direct payment through cafeteria plans
- dependent-care spending accounts (tax savings)
- voucher programs
- company discounts

Whatever type of childcare you choose—in-home, family, or center-based be sure to consider these factors:

- **Quality of adult/child relationships**--Are staff members specially trained in child development and early education? Are children cared for in small groups and given activities according to their level of development? Are there enough trained adults available to children on a regular basis?
- **Location**--How far will the care be from home? From work? Is this convenient for both parents? Can both parents easily get there in an emergency?
- **Hours**--What hours of care are needed? What happens if you are late in picking up your child?
- **Alternative arrangements**--What happens if your child is sick? When the caregiver cannot come? What if the childcare program is closed? What pediatric medical care is available to the program?
- **Consistency**--Are the program's policies on meals, discipline, and toilet training the same as your views at home? Will your child be able to have a stable relationship with one caring adult?
- **Parent responsibility**--It is ultimately your responsibility to ensure that your child receives the best care. Talk with the caregiver on a regular basis. Plan to spend time with your child and the caregiver every day, both before you leave and when you return. When problems occur, your home caregiver or staff at the child care center should be able and willing to help you work through the situation. If problems persist and you suspect your child's health or safety is in question, find another child care arrangement for your child right away.

## Questions to Ask

Finding quality childcare is important. Standards for childcare settings may vary depending on the type of childcare. Use the following list of questions when visiting childcare settings to help you decide the childcare option that is best for you and your child.

### **What to look for**

1. Do the child:staff ratios and the size of groups meet or exceed recommended levels? (See chart.)
2. Does the staff appear to enjoy caring for the children?
3. Is the center or home bright, cheerful, and well ventilated? Is all equipment clean, safe, and well maintained?
4. Do the children in the program appear to be happy?
5. Is the noise level in the child care areas comfortable?
6. Do the adults and the children often talk with each other? Are children encouraged to talk with each other?
7. Is the indoor space large enough? Look for 50 square feet, measured wall-to-wall, per child.
8. Is there a sleeping or quiet area large enough for all the children to rest during naptime? (There should be at least 3 feet of space between children sleeping in a head-to-toe manner.)
9. Does each child have a place for his or her own belongings?
10. Are infants always fed in an upright position and, until they can sit by themselves for feeding, held by an adult? (No bottles are allowed in bed or propped.)
11. Is all the food nutritious, well prepared, well served, and age-appropriate? Are you able to check the menus and meal plans in advance?
12. Are there many toys present that are accessible, safe, and appropriate for your child's age group?
13. Is there protective surfacing under indoor climbing equipment? Indoor climbers require the same types of impact-absorbing materials and fall zones as those installed outdoors.
14. Is there an outside playing area that is free of sharp edges, pinch points, sharp rocks, and ditches?
15. Is the outside area free of hazards such as hard surfaces, sharp rocks, high climbers, tall slides, unprotected seesaws and merry-go-rounds, and unsafe swings?
16. Is equipment age-appropriate, properly installed, and well maintained?
17. Is there impact-absorbing material such as soft sand, wood chips, smooth gravel, or specially manufactured rubber mats under and at least 6 feet out from equipment?
18. Are there individual cribs, beds, cots, or mats to sleep on? Do sleeping children stay within view of caregivers?
19. Is there a clean diaper-changing area for infants and toddlers? Is a sink within the caregiver's reach near the diaper-changing surface?
20. Are the toilets and sinks clean and easy to reach? Can children reach clean towels, liquid soap, and toilet paper?
21. Do caregivers wash hands after changing diapers, wiping a runny nose, or helping a child with toileting?
22. Do caregivers make sure that children wash their hands after toileting, playing outside, and before meals?
23. Does each child have his or her own separate wash cloth and towel?
24. Are there sinks in each room, with a separate sink for food preparation and hand washing?
25. Does the center or home appear to be clean and safe for your child?

Age	Child:Staff ratio	Maximum group size
Birth—24 months	3:1	6
25—30 months	4:1	8
31-35 months	5:1	10
3 year olds	7:1	14
4 year olds	8:1	16
5 year olds	8:1	16
6—8 year olds	10:1	20
9—12 year olds	12:1	24

**What to ask**

1. Is the childcare center or home licensed or registered with local government? Has the program achieved accreditation by a nationally recognized independent group of early childhood professionals? (Ask to see a current document and find out what type of inspection or review was done.)
2. Are you welcome to visit the facility during normal operating hours before and after registering your child in the program?
3. Can you see all areas your child will use?
4. Is there a written plan for play and learning activities that includes active play, quiet play, nap or rest time, and snacks and meals? (Ask to see it.)
5. Are there daily opportunities for inside and outside play, and are children supervised at all times?
6. Is television viewing limited to short times and age-appropriate programs?
7. Does the center offer parenting education classes or other family support?
8. Is each child assigned to one caregiver that is primarily responsible for his or her care and whereabouts, even if other caregivers are sometimes involved?
9. Does the caregiver regularly meet with parents? (Ask how often.)
10. Is there a written policy about discipline? (Ask to read it.)
11. Is smoking banned from the childcare center or home?
12. Are there written policies and plans for the care of ill children that include the responsibilities of parents? (Ask to see the policies.)
13. Is there a quiet, well-supervised arrangement for the care of ill children until parents pick them up?
14. Will the caregivers give prescribed medications to your child? (If yes, under what conditions?)
15. Is there a health specialist, such as a pediatrician, who serves as a consultant for the child care program?
16. Are staff members and volunteers trained in child development?
17. Are you comfortable with the experience and qualifications of the staff?

18. Are the staff members and volunteers trained in first aid, injury prevention, emergency response to choking, and prevention of infections?
19. Does the caregiver perform monthly evacuation and emergency drills and monthly playground checks?
20. What are the arrangements if a caregiver gets sick or has to be away?
21. Can you get recommendations and advice from parents whose children are currently in the program?
22. Did the center explain to you all the costs and fees involved with your child's care?

### **Different children, different care**

The key to good childcare is whether the caregiver can adapt to the needs of children and families. Not all children of the same age are at the same level of development; each child has unique character traits. A good caregiver understands these personal and developmental differences and creates a program to meet each child's needs.

When your child is an infant, the number of caregivers should be limited. Your child can only form a trusting relationship with a few people. Most young infants thrive when they have steady, positive relationships with their caregivers. Close contact aids your child's social and emotional growth. Your infant becomes used to a certain tone of voice, way of being held, etc. The caregiver also learns to recognize your infant's cues for distress, hunger, and playfulness. Even if more than one adult works with the group, one adult should have primary responsibility for your child.

## **Helping your child adjust to day care.**

When you take your child to day care for the first day, plan on spending enough time at the daycare to make sure your baby is comfortable in his new environment. On the second day, stay 5 or 10 minutes while your child makes the transition to interacting with the day care provider. If possible, leave a familiar toy or security object with your child. If the day care center is near your workplace, visit your child during the day. When you leave your child, do so with a cheerful attitude and let your child know you are leaving--don't sneak away. Let your child gradually reach out and become involved with the other children and the caregiver(s)

### **Preparing your child**

Most young infants, up to 7 months, adapt to caring adults and seldom have problems adjusting to good childcare. Older infants may be upset when left with strangers. They will need extra time and your support to "get to know" the caregiver.

You can reduce your child's fears about starting childcare. Visit the program or family childcare home with your child before beginning care. Show your child that you like and trust the caregiver. Arrange a visit with in-home providers while you are at home or when you need childcare for a short time. Some children like to carry a reminder of home when they go to childcare. A family photograph or small toy can be helpful. Talking to your child about childcare and the caregiver is helpful. Preparation and familiarity make any new experience easier for children. There also are storybooks about childcare that you and your child can read together. (Check with your local library.)

After a child has been in childcare, a sudden change in caregivers may be upsetting. This can happen even if the new caregiver is kind and competent. If you are concerned about your child's feelings, you may want to arrange a meeting with the caregiver or ask your pediatrician for advice. Parents need to help the caregivers and the child deal with any changes in the child's routine at home or childcare.

Good childcare helps children grow in every way and promotes their physical, social, and mental development. It offers support to working parents. Your pediatrician wants your child to grow and develop with enjoyment in a setting that supports you as a parent.

For further information on childcare and early education, contact:

- National Association for the Education of Young Children, 1509 16th Street, NW, Washington, DC 20036-1426.
- National Association of Child Care Resource and Referral Agencies, 1319 F Street, NW, Suite 810, Washington, DC 20004
- Child Care Aware: 800/424-2246

## **Caring for a sick child.**

The onset of illness can be a major disruption for the mother working outside the home. Many day care homes and centers will not care for sick children. Your options usually are staying home with your child, having your spouse take time off from work and stay home with your child, or having your child stay with a friend or relative who has agreed in advance to be a backup for illness care.

If your child becomes sick during the working day and you think he needs to see a physician, try to arrange for a late-afternoon appointment by calling before 3:00 PM.

Children with a sore throat, moderate cough, runny nose, or cold symptoms (but without a fever or breathing difficulties) can usually stay in or return to day care. The decision should be based mainly on how well your child feels. Children with fevers (over 100 degrees F, or 37.8 degrees C), chickenpox, vomiting, or diarrhea cannot stay in a regular day care setting. Children with a strep throat or an eye infection can usually return after 24 hours on an antibiotic. Many childcare centers have their own rules about when a sick child must stay at home. You should become familiar with these rules.

If your child gets sick. Make sure that your childcare provider can always reach you. Many times children are allowed to stay with their child care provider as long as they can participate in most of the activities. If the child needs extra rest, there must be a place to lie down and still be observed.

Sometimes children need medications while they are at childcare. Both prescription and over-the-counter medications should have a pharmacy label with the child's name, dosage, and expiration date. The childcare provider should know when and how to safely give the medication and properly record each dose.

## Challenges for Mothers working Outside the Home

- 1. Look for a supportive employer and workplace.** Being a mother who is working outside the home can be harder and more stressful than being a mother who stays home because your other responsibilities are never completely filled by other people. To lessen the burden, consider working only part-time if it's financially acceptable. Perhaps you can share a job with another person, so that each of you works 20 hours a week. Or perhaps your employer will allow you to have a flexible schedule or to work at least some of the time in your home.
- 2. Avoid fatigue.** If you don't get enough sleep, nothing will seem to turn out right. Pick a reasonable bedtime and stay with it. Cut corners in other areas but protect your sleep time.
- 3. Provide contact time with your child.** Research has shown that both the quality and quantity of time you spend with your child are important. Try to make breakfast a pleasant, unhurried occasion. Try to talk with your child during the commute to and from the child care provider. Use the 30 minutes before bedtime to discuss the day's events with your child at your child's pace. Set aside special half-days on weekends to do things with your child. Also remember that including your child in adult activities such as shopping, cooking, washing, and home repair is also quality time. You are providing enough input if your child is usually happy.
- 4. Reduce your housework time.** If you can afford it, hire a housekeeper. In any case, try to simplify your home life. A spotless house must become a low priority. Do less cooking; make triple recipes and freeze leftovers. In addition, make a date for a night out with your spouse or a friend at least once a week; relaxation time is essential, not frivolous or wasteful.
- 5. Ask other family members for help.** It is imperative that spouses participate in the housework and childcare. Responsibility for these tasks must be redistributed to prevent the mother from becoming overworked. For example, the father can help buy a son's clothing, take the children places, cook, and clean the house. School-age children can also be assigned some chores.
- 6. Watch out for feelings of guilt.** Try to understand that "Supermom" is a myth. You can't do everything single-handedly or perfectly. You need help and deserve help. If you have found a good child care provider, you should feel comfortable during the day about your child's well being. Despite your best efforts, your child will sometimes cry when dropped off at day care and will sometimes become sick. Try not to rethink your career decision every time this happens.
- 7. Find extra help if you are a single parent.** Try to find a friend with a child close in age to yours. Share shopping, overnight and weekend visits, baby-sitting, and other responsibilities with your friend. Trading services in this way will save you money. Living with another single mother may be mutually beneficial. Consider joining an organization for single parents.

## Recommended Reading

T. Berry Brazelton, *Working and Caring* (Reading, Mass.: Addison-Wesley, 1992).  
Earl A. Grollman, et al., *The Working Parent Dilemma* (Boston: Beacon Press, 1988).

# NEWBORN DEVELOPMENT

## Developmental stimulation

The most rapid changes in development occur during the first year of life. A baby grows from a helpless little bundle into a walking, talking, unique personality. Almost all parents wonder if their baby is developing at the right pace. There is wide variation in normal development. Although the average child walks at 12 months, the normal age for walking is any time between 9 and 16 months of age. Motor development occurs in an orderly sequence, starting with lifting the head, then rolling over, sitting up, crawling, standing, and walking. Although the sequence is predictable and follows the maturation of the spinal cord downward, the rate at which these stages happen varies. Speech develops from cooing to babbling, to imitating speech sounds, to first words, to using words together. Again, however, the normal rate can vary considerably.

The most reassuring signs that a child is developing normally are an alert facial expression, alert eyes, and curiosity about his or her surroundings. The main determinant of a child's social, emotional, and language development is the amount of positive contact he or she has with his parents. The experiences during the first 3 years of life determine the permanent "wiring" of the brain.

## Ways to Stimulate Your Child's Normal Development

- 1. Hold your baby as much as possible.** Touching and cuddling is good for your baby. Give him or her lots of eye contact, smiles, and affection. Use feedings as a special opportunity for these warm personal interactions.
- 2. Talk to your baby.** Babies of all ages enjoy being talked and sung to. Babies must first hear language before they can use it themselves. You don't need a script--just put into words whatever you are thinking and feeling.
- 3. Play with your baby.** If this doesn't come easy for you, try to loosen up and rediscover your free spirit. Respond to your baby's attempts to initiate play. Provide your baby with various objects of interest. Toys need not be expensive; for example, homemade mobiles, rattles, spoons, pots and pans, and boxes. Encourage your baby's efforts at discovering how to use his or her hands and mind.
- 4. Read to your baby.** Even 4-month-olds enjoy looking at pictures in a book. Cut out interesting pictures from magazines and put them in a scrapbook for your baby. Look at the family photo album. By 8 months of age, begin reading stories to your child.
- 5. Show your baby the world.** Enrich his or her experience. Point out leaves, clouds, stars, and rainbows. Help your toddler describe what she sees or experiences. Everything we see or do has a name.
- 6. Provide your child with social experiences with other children by age 2 years.** If he or she is not in day care, consider starting or joining a play group. Young children can learn important lessons from each other, especially how to get along with other people.

**7. Avoid formal teaching until age 4 or 5.** Some groups have recently overemphasized academic (cognitive) development of young children. The effort to create “superkids” through special lessons, drills, computer programs, and classes can put undue pressure on young children and may result in an early loss of interest in learning. Old-fashioned creative play and spontaneous learning provide a foundation for later academic efforts and are much more beneficial during the early years.

## Developmental Milestones

Watching a young child grow is a wonderful and unique experience for a parent. Learning to sit up, walk, and talk are some of the more major developmental milestones your child will achieve. But your child’s growth is a complex and ongoing process. Young bodies are constantly going through a number of physical and mental changes.

Although no two children develop at the same rate, they should be able to do certain things at certain ages. As a parent, you are in the best position to note your child’s development, and you can use the milestones described in this brochure as guidelines.

At the ages noted in this brochure, observe your child for 1 month. (This lets you take into account any days when your child may be acting differently because she is sick or upset.) Use the milestones listed for each age to see how your child is developing.

Remember, a “No” answer to any of these questions does not necessarily mean that there is a problem. Every child develops at his own pace and may sometimes develop more slowly in certain areas than other children the same age. Keep in mind these milestones should be used only as guidelines.

Plan to talk about these guidelines with your pediatrician during your next office visit if you note the following:

- Major differences between your child’s development and the milestones.
- Your child does not yet do many of the things usually done at her age.

### 3 months

- |   |            |           |
|---|------------|-----------|
| 1. When your baby is lying on his back, does he move each of his arms equally well? Check “No” if your baby makes jerky or uncoordinated movements with one or both of his arms or legs, or uses only one arm all the time. | <b>yes</b> | <b>no</b> |
| 2. Does your baby make sounds such as gurgling, cooing, babbling, or other noises besides crying?   | <b>yes</b> | <b>no</b> |
| 3. Does your baby respond to your voice?  | <b>yes</b> | <b>no</b> |
| 4. Are your baby’s hands frequently open?   | <b>yes</b> | <b>no</b> |
| 5. When you hold your baby in the upright position, can she support her head for more than a moment?  | <b>yes</b> | <b>no</b> |

### 6 months

- |   |     |    |
|---|-----|----|
| 1. Have you seen your baby play with his hands by touching them together?   | yes | no |
| 2. Does your baby turn her head to sounds that originate out of her immediate area?   | yes | no |
| 3. Has your baby rolled over from his stomach to his back or from back to stomach?  | yes | no |
| 4. When you hold your baby under her arms, can she bear some weight on her legs? Check "Yes" only if she tries to stand on her feet and support some of her weight. | yes | no |
| 5. When your baby is on his stomach, can he support his weight on outstretched hands?   | yes | no |
| 6. Does your baby see small objects such as crumbs?   | yes | no |
| 7. Does she react to the emotions of others?  | yes | no |
| 8. Does your baby produce a string of sounds?   | yes | no |
| 9. Does your baby begin to relax when you read him a bedtime story?   | yes | no |
| 10. Does your baby notice herself and her actions in a mirror?  | yes | no |
| 11. Does your baby reach out for you to pick him up?  | yes | no |

### 9 months

- |   |     |    |
|---|-----|----|
| 1. When your baby is playing and you come up quietly behind her, does she sometimes turn her head as though she hears you? (Loud sounds do not count.) Check "Yes" only if you have seen her respond to quiet sounds or whispers. | yes | no |
| 2. Can your baby sit without support and without holding up his body with his hands?  | yes | no |
| 3. Does your baby crawl or creep on her hands and knees?  | yes | no |
| 4. Does your baby hold his bottle?  | yes | no |
| 5. Does your baby deliberately drop or throw toys?  | yes | no |
| 6. Does she bang, strike, and shake her toys?   | yes | no |
| 7. When you show your baby a book, does he get excited, then try to grab and taste it?  | yes | no |
| 8. Is your baby wary of unfamiliar people?  | yes | no |
| 9. Does your baby make sounds that use vowels and consonants?   | yes | no |

### 12 Months

- |   |     |    |
|---|-----|----|
| 1. When you hide behind something or around a corner and then reappear, does your baby look for you and eagerly plan for you to reappear? | yes | no |
| 2. Does your baby pull up to stand?   | yes | no |
| 3. Does your baby make 'ma-ma or da-da' sounds? Check "Yes" if she makes either sound   | yes | no |
| 4. Does your baby walk holding on to furniture?.  | yes | no |
| 5. Does your baby say at least one word?  | yes | no |
| 6. Is your baby able to locate sounds by turning his head?  | yes | no |
| 7. Does your baby imitate familiar adult behavior, such as using a cup or telephone?  | yes | no |
| 8. Does your baby turn her books face up, but turn several pages at once?   | yes | no |
| 9. Does your baby look for and find toys?   | yes | no |
| 10. Does your baby eagerly explore objects and spaces?  | yes | no |

### 18 Months

- |   |            |           |
|---|------------|-----------|
| 1. Can your child hold a regular cup or glass without help and drink from it without spilling?        | <b>yes</b> | <b>no</b> |
| 2. Can your child walk all the way across a large room without falling or wobbling from side to side? | <b>yes</b> | <b>no</b> |
| 3. Does your child feed herself?  | <b>yes</b> | <b>no</b> |
| 4. Does your child take off his shoes by himself?   | <b>yes</b> | <b>no</b> |
| 5. Does your child clearly look to his parents in stressful situations?                               | <b>yes</b> | <b>no</b> |
| 6. Does your child have temper tantrums?  | <b>yes</b> | <b>no</b> |
| 7. Does your child say at least 4 to 10 words?  | <b>yes</b> | <b>no</b> |
| 8. Does your child point to a picture that you name in a book?  | <b>yes</b> | <b>no</b> |
| 9. Does your child pretend to talk?   | <b>yes</b> | <b>no</b> |

### 2 Years

- |  |            |           |
|--|------------|-----------|
| 1. Can your child say things like "all gone," go bye-bye," or other two-word sentences?  | <b>yes</b> | <b>no</b> |
| 2. Does your child say about 50 words?   | <b>yes</b> | <b>no</b> |
| 3. Can your child take off clothes such as pajamas (tops or bottoms) or pants? (Diapers, hats, and socks do not count.)                  | <b>yes</b> | <b>no</b> |
| 4. Does your child run without falling?  | <b>yes</b> | <b>no</b> |
| 5. Does your child look at pictures in a picture book?   |            |           |
| 6. Does your child carry around a favorite book and pretend to read it to you?   | <b>yes</b> | <b>no</b> |
| 7. Does your child tell you what she wants?  | <b>yes</b> | <b>no</b> |
| 8. Does your child repeat words others say?  | <b>yes</b> | <b>no</b> |
| 9. Does your child point to at least one named body part?  | <b>yes</b> | <b>no</b> |
| 10. Does your child participate in play with other children? Does your child show increasing independence, wanting to do things his way? | <b>yes</b> | <b>no</b> |
| 11. Does your child like to collect or hoard things?   | <b>yes</b> | <b>no</b> |

### 3 Years

- |  |            |           |
|--|------------|-----------|
| 1. Can your child name at least one picture when you look at animal books together?  | <b>yes</b> | <b>no</b> |
| 2. Does your child enjoy sitting together for at least 5 minutes for story time?   | <b>yes</b> | <b>no</b> |
| 3. Can your child answer "what" questions about the story that you have just read together?                                | <b>yes</b> | <b>no</b> |
| 4. Can your child throw a ball overhand (not sidearm or underhand) toward your stomach or chest from a distance of 5 feet? | <b>yes</b> | <b>no</b> |
| 5. Do most adults easily understand your child?  | <b>yes</b> | <b>no</b> |
| 6. Does your child help put things away?   | <b>yes</b> | <b>no</b> |
| 7. Can your child answer the question, "Are you a boy or girl?"  | <b>yes</b> | <b>no</b> |
| 8. Can your child name at least one color?   | <b>yes</b> | <b>no</b> |
| 9. Does your child talk in three-word sentences most of the time?  | <b>yes</b> | <b>no</b> |

#### 4 Years

1. Can your child pedal a tricycle at least 10 feet forward?	<b>yes</b>	<b>no</b>
2. Does your child play hide-and-seek, cops-and-robbers, or other games where she takes turns and follows rules?	<b>yes</b>	<b>no</b>
3. Does your child turn paper pages in a book one at a time?	<b>yes</b>	<b>no</b>
4. Does your child retell stories that are familiar?	<b>yes</b>	<b>no</b>
5. Can your child tell you what action is taking place in a picture?	<b>yes</b>	<b>no</b>
6. Does your child use action words (verbs)?	<b>yes</b>	<b>no</b>
7. Does your child play pretend games, such as with toys, dolls, animals, or even an imaginary friend?	<b>yes</b>	<b>no</b>
8. Can your child copy a circle?	<b>yes</b>	<b>no</b>
6. Does your child pretend to write, making marks on a page that only he can read?	<b>yes</b>	<b>no</b>
7. Does your child mostly use four-word or five-word sentences when talking?	<b>yes</b>	<b>no</b>

#### 5 Years

1. Can your child button some of her clothing or her doll's clothes? (Snaps do not count.)	<b>yes</b>	<b>no</b>
2. Does your child react well when you leave him with a friend or sitter?	<b>yes</b>	<b>no</b>
3. Can your child name at least three colors?	<b>yes</b>	<b>no</b>
4. Can your child walk down stairs alternating her feet?	<b>yes</b>	<b>no</b>
5. Can your child point while counting at least three different objects?	<b>yes</b>	<b>no</b>
6. Can your child jump with his feet apart (broad jump)?	<b>yes</b>	<b>no</b>
7. Can your child name a coin correctly?	<b>yes</b>	<b>no</b>
8. Does your child like to relax together with you for 10 to 20 minutes of story time?	<b>yes</b>	<b>no</b>
9. Can your child copy a square?	<b>yes</b>	<b>no</b>
10. Can your child name at least some letters of the alphabet when she sees them?	<b>yes</b>	<b>no</b>
11. Can your child identify and print the first letter in his name?	<b>yes</b>	<b>no</b>
12. Can your child recognize and name several single numbers?	<b>yes</b>	<b>no</b>
13. Does your child recognize common street and store signs (e.g., 'Stop,' 'Open')?	<b>yes</b>	<b>no</b>

#### 6 Years

1. Can your child tie her shoes?	<b>yes</b>	<b>no</b>
2. Can your child catch a small bouncing ball, such as a tennis ball, using only her hands? (Large balls do not count.)	<b>yes</b>	<b>no</b>
3. Can your child dress himself completely without help?	<b>yes</b>	<b>no</b>
4. Can your child skip with both feet?	<b>yes</b>	<b>no</b>
5. Can your child tell his age correctly?	<b>yes</b>	<b>no</b>
6. Can your child repeat at least four numbers in the proper sequence?	<b>yes</b>	<b>no</b>
7. Can your child recognize and name at least 10 letters in the alphabet?	<b>yes</b>	<b>no</b>
8. Does your child know the sounds of most letters of the alphabet?	<b>yes</b>	<b>no</b>
9. Can your child recognize and read 15 or more common words?	<b>yes</b>	<b>no</b>
10. Can your child copy a few simple words from a book?	<b>yes</b>	<b>no</b>

As a parent, you are in the best position to note these subtle aspects of your child's behavior. These clues signal that your child's development is on schedule or that something might be wrong. A No" answer to any of the questions may be a warning sign. Make sure to bring it to your pediatrician's attention. Remember that these milestones are an aid, not a test.

If you have any questions, plan to discuss them with your pediatrician. Pediatricians are trained to detect and treat developmental problems in children. Many problems, if detected early, can be treated by your pediatrician and successfully managed.

## **WHAT DO I DO NOW?**

The rest is up to you. You will raise your child as you see fit. **YOU'RE THE PARENT NOW.** Of course we will always be here to help you make the important medical decisions concerning your child. Each scheduled check-up we will give you more information to add to this binder with advice we have selected to help you. Feel free to add and subtract from this as you like. Hopefully this will become an important resource to you as you face the myriad of questions that come from parenthood.