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Medical Services

Pediatric Guide for Parents

***This pamphlet supersedes USAREUR Pamphlet 40-2, 24 May 2000.**

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Summary. This pamphlet is intended expand "Taking Care of Your Child" (sixth edition), which is distributed by the TRICARE Europe Program to each family served by the program. Because some information in Taking Care of Your Child is outdated or does not completely address topics of concern to U.S. military families stationed in Europe, families should refer to this pamphlet before referring to Taking Care of Your Child.

NOTE: Go immediately to Taking Care of Your Child for information on cardiopulmonary resuscitation (CPR), choking, and other emergencies. Parents should know the emergency telephone numbers to contact an ambulance where they live. Parents should post these emergency numbers by their telephones or program the numbers in the telephone memory, if available.

Summary of Change. This revision--

- Incorporates information on blood tests for newborn infants.
- Incorporates information on the Women, Infants, and Children (WIC) Overseas Program.
- Recommends that infants be on their back when sleeping.
- Incorporates additional information on fevers.
- Instructs parents to have their child evaluated by a physician if the child has a febrile seizure (convulsion) for the first time.
- Deletes information about the oral polio vaccine.

Applicability. This pamphlet applies to everyone served by the United States Army Europe Regional Medical Command.

Forms. AE and higher-level forms are available through the Army in Europe Publishing System (AEPUBS).

Records Management. Records created as a result of processes prescribed by this regulation must be identified, maintained, and disposed of according to AR 25-400-2. Record titles and descriptions are available on the Army Records Information Management System website at *https://www.arims.army.mil.*

Suggested Improvements. The proponent of this pamphlet is the Office of the Command Surgeon (OCSURG), HQ USAREUR/7A (AEAMD, DSN 371-2670). Users may suggest improvements to this pamphlet by sending DA Form 2028 through the OCSURG, HQ USAREUR/7A (AEAMD-X), Unit 29351, APO AE 09014-9351, to the United States Army Europe Regional Medical Command (MCEU-XO), CMR 442, APO AE 09042.

Distribution. C (AEPUBS).

Endorsement. The Department of Defense does not sanction or endorse any commercial product, service, or enterprise mentioned in this pamphlet.

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SECTION I
PEDIATRIC SERVICES AVAILABLE AT U.S. ARMY HOSPITALS IN EUROPE

Parents and U.S. military medical facility pediatric staff share the responsibility for providing the best health care to children. The pediatricians of the United States Army Europe Regional Medical Command strive to provide efficient, comprehensive care to patients on a personal basis, within the means allowed by the United States Army Medical Department. Pediatric inpatient and outpatient care is available at the three U.S. Army hospitals in Europe. These hospitals are in Heidelberg, Landstuhl, and Würzburg, Germany. Medical care for children who live elsewhere is provided by primary-care providers in outpatient clinics and by preferred host-nation providers. Parents should check with their community services to learn how best to access appropriate emergency and routine services for their children. Emergency care should generally be provided by the nearest emergency room. Do not put your child at increased risk by driving longer distances to reach an American military hospital.

SECTION II
NEWBORN INFANT CARE

NEW PARENT EDUCATION AND SUPPORT PROGRAM

The New Parent Education and Support Program (NPESP) is the Army's outreach program for expectant and new parents. NPESP programs and services contribute to mission readiness, support family adaptation to military life, and enhance the knowledge and skills that families need to form healthy relationships and provide safe, nurturing environments for their children. The NPESP offers support and educational, informational, and referral services. Expectant and new parents should contact their local Army community service center for more information.

PARENT-CHILD RELATIONSHIPS

The arrival of a new baby is a wonderful time, but also a time of adjustment. After 9 months of waiting and worrying and after the exhausting, exhilarating experience of giving birth, you will undergo changes in both your family and personal life. The changes will be exciting and trying. You will learn to be a parent in the process of parenting. Each child will show you what he or she needs if you take the time to observe the child.

Mothers. Women react to the changes motherhood brings in a variety of ways. Some new mothers easily slip into the role of constant attendant of a helpless child. Others feel tied down or depressed. If you fall into the latter group, do not feel like a bad mother. Mothering skills develop at different rates. If you need support, turn to your husband, friends, or primary-care providers. If you are an active mother and decide to breast-feed your child, spend the first few weeks of motherhood concentrating on eating, drinking, and resting so that nursing does not become a negative experience. Let your husband take care of the shopping and the housework. Concentrate on enjoying the new baby. The first 3 weeks will establish your feeding rhythm. The more you relax during this time, the easier subsequent months will be. If you have other children, take a nap when they do. A front baby-carrier is a good investment. Front carriers give you the opportunity to pick up your crying baby and do necessary things around the house without feeling you are neglecting your child. Recognize your needs and your family's needs. Maximize the joy of having a new family member by setting priorities to minimize stress.

Fathers. Parenthood also brings a great deal of adjustment to fathers. Suddenly your wife is not always available to you. This can cause jealousy. If you are jealous of your child, do not feel guilty. Jealousy is normal. Getting involved with caring for the child and helping your wife adjust to motherhood will help you adjust to fatherhood and make your family stronger.

BLOOD TESTS FOR NEWBORN INFANTS

All infants are screened before leaving U.S. military hospitals (after 24 hours of milk feeding) by having a few drops of blood taken from their heel. The test is repeated at the 2-week, well-baby visit. These blood tests are used to determine if your child has any of the following rare diseases: phenylketonuria (PKU), hypothyroidism, galactosemia, homocystinuria, sickle-cell anemia or other hemoglobinopathies, maple syrup urine disease, congenital adrenal hyperplasia, and biotinidase abnormalities. Even healthy-looking babies can have these diseases. If any of these diseases are not treated, a serious and possibly fatal problem could arise. Your doctor will contact you if these tests show abnormalities and advise you on confirmatory tests or treatment.

If your baby is born in a host-nation hospital, go to your local U.S. military clinic (primary-care provider) to have the blood test done at your baby's 2-week, well-baby visit.

BREAST-FEEDING

General. Feeding is one of your baby's first pleasurable experiences. The baby's first love for his or her mother grows during feeding. During feedings, the baby receives both dietary nourishment and affection from the mother, which help the baby feel happy and secure.

Beginning Breast-Feeding. There is usually no reason to be concerned as to whether or not your breasts can produce milk. Babies usually are not interested in breast-feeding during the first few days of life. Milk production starts about the same time babies become interested, which is usually the third day after the delivery.

Schedules. Feeding schedules are usually most satisfactory if the hours are set loosely and if your baby is allowed to eat when hungry. An interval of 2 to 5 hours between feedings is normal. During the first week of life, your baby should be awakened to feed every 3 hours. Gradually the time between feedings will lengthen and after a few weeks, you will find yourselves falling into a flexible schedule acceptable to both of you.

If your baby occasionally awakens and cries 1 to 2 hours after feeding, the child probably is not hungry. If your baby consistently awakens and cries soon after a feeding, the child may not be receiving enough food or may be in a growth spurt. If you are breast-feeding, nurse more frequently and pay attention to your diet. Within a week, your milk supply should meet the increased demand and your baby will once again settle down to the usual schedule.

The baby may have a minor illness that is causing him or her to be fussy. The baby's doctor or nurse can determine if the child has a minor illness. The best way to determine if your baby is getting enough milk is to weigh him or her during regular well-baby clinic checks. If your baby is slow to gain weight, your physician may ask you to return the child more frequently for naked weight checks.

Nipple Care. To condition your nipples, expose them to air by leaving the bra flaps down as often as possible. Wash your nipples only one or two times a day. Gently rinse your nipples with plain water daily. Avoid using soap or alcohol on your breasts, as they tend to dehydrate the nipples. Keep your nipples dry by air-drying them for 15 to 20 minutes after each feeding or by using a blow-dryer on a cool setting for 2 minutes on each breast.

If your breasts leak, do not cover them with nursing pads between feedings; the use of the pads may cause the development of thrush, which is a fungal skin infection. Avoid using plastic nursing pads and liners.

Inverted or Flat Nipples. Some women have nipples that are flat or inverted. This may be frustrating for the mothers and their babies. An exercise that may help the nipple protrude is to massage the nipple between the thumb and forefinger for 1 or 2 minutes. Do this twice a day before feeding your baby.

Cracked Nipples. If your nipples become cracked, apply a thin layer of breastmilk, lanolin, or vitamin E gel. You can get the gel by piercing a vitamin E capsule with a pin. Wipe the vitamin E gel off before breast-feeding, because the baby could swallow too much gel over time.

Feeding Techniques. The nurse in the newborn nursery can teach you breast-feeding techniques. Below are a few tips for making breast-feeding a pleasurable experience for you and your baby:

- Before feeding your baby, wash your hands. Choose a chair or position that is comfortable for you, and remain calm and relaxed during the feeding. Keep your baby warm, dry, and comfortable. Hold the baby in your lap, comfortably close, with the child's head raised slightly. This environment encourages a contented baby and good milk flow.

- Breast-fed babies may initially feed every 2 to 4 hours. Let your baby nurse at each breast each feeding time. Alternate the starting breast. You may identify the starting breast by marking it with a safety pin attached to your bra.

- Let your baby nurse 10 to 15 minutes per breast. Thirty minutes is usually long enough for any breast-feeding session. Your baby may feed slightly longer on the starting breast than on the other. While in the hospital, if you have problems or discomfort with breast-feeding, talk to a nursery nurse. If you have problems or questions with breast-feeding at home, call the baby's primary-care manager, the mother/baby unit, or the La Leche League.

- Before putting the baby to your breast, squeeze out a small amount of your breastmilk. Gather the nipple and bring the baby's cheek into contact with your breast. Your baby's "rooting reflex" will help him or her find the nipple. Your baby should take as much of the areola (dark area around your nipple) into his or her mouth as possible. If your breast is especially large or very full with milk, press your finger on the breast to keep it away from the baby's nose so the child can breathe while he or she is feeding.

- When it is time for your baby to stop nursing, insert your finger into the side of the child's mouth to break the suction. Do not try to pull the child off the nipple; doing so will cause the baby to tighten his or her mouth, which can be quite painful to you.

- To avoid sore nipples, alternate the position you use when feeding your baby. Each position will drain a different part of your breast. During the first week of breast-feeding, change your baby's position at least every other feeding. Breast-feeding positions include the cradle hold, the football hold, and the side-lying hold. Other positions may also work for you and your baby.

Reducing Stress. A mother and her infant have a very special relationship. They communicate through body language. You may notice that your baby is irritable and cries when you feel tired. Getting emotionally upset can interfere with your milk production and you may communicate your tension to your baby. The best treatment for stress is prevention. You may prevent tension by following these procedures:

- Avoid fatigue by resting often.

- Nurse your baby in a quiet room when you are unhurried and can relax mentally and physically.

- Practice tension-reducing activities that work best for you. Soak in a warm bath, breathe slowly and deeply, listen to soft music, drink juice (instead of coffee), or talk with a friend.

- Give yourself permission to postpone some of the tasks you would regularly do, such as vacuuming or washing dishes.

Mother's Diet. You should drink at least 2 to 3 quarts of fluids each day while breast-feeding. It is not necessary to drink milk to produce milk for breast-feeding. Drink a variety of beverages daily. You may drink a small amount of alcoholic beverages, such as a small glass of wine, but not more than once a day. Eat well-balanced meals. Do not diet while you are breast-feeding. If you eat or drink large amounts of chocolate, coffee, soda, or tea, the caffeine in these items can pass into your breastmilk and may make your baby irritable. Nicotine from cigarettes also passes into breastmilk and can disturb your baby.

A mother's diet affects the quality and quantity of breastmilk. You should eat about 3,000 calories a day; foods should be rich in protein, calcium, and vitamins. Vitamin B is especially important. Nursing mothers should eat meat (especially organ meat), milk, cheese, yogurt, eggs, whole-grain breads and cereals, leafy green vegetables, and fruit. Sweets and snack foods, while good for extra calories, will depress the mother's appetite for more nutritious foods. Mothers who breast-feed should take supplementary vitamins and iron. Although women who breast-feed can eat almost any food in moderation, some babies get fussy or have gas when their mothers eat a particular food. If this applies to your baby, eat small portions of that food. Discuss using medicines with your physician.

Father's Role. Perhaps the single most important factor for successful breast-feeding is a patient, supportive father. The father may bottle-feed the child "expressed" breastmilk or formula once a week to help the baby learn how to drink from a bottle. (Expressed milk is milk that the mother presses or pumps from her breast either by hand or with a breast pump.)

Lumps in Breast. If there are lumps in your breast (from clogged milk ducts), nurse more frequently and use a different position each time the baby feeds. If you develop a fever or become very tired, promptly seek medical advice from the obstetrics and gynecology clinic or from your primary-care provider.

Nursing in Public. Do not feel embarrassed about nursing in public. You can drape a baby blanket or diaper over your shoulder or pull up a loose-fitting blouse or sweater to cover yourself while your baby feeds.

Supplementation. One should not supplement breast-feeding with formula during the first 4 to 6 weeks of nursing; the breast is adjusting to your baby's demand. After this period you can leave the baby with a sitter and a bottle while you occasionally go out. Many mothers who go back to work nurse their babies during lunch breaks and off-duty hours and supplement the feedings with bottles (formula or their own breastmilk) during workhours.

Vitamin D. Vitamin D is obtained from exposure to sunlight and through diet. Breastmilk doesn't contain Vitamin D and therefore your physician may recommend daily supplementation.

Breastmilk Supplements. If you are unable to personally feed your child, you can express your milk by hand or with a breast pump. Breastmilk should be stored in glass bottles or plastic bags (such as Gerber or Playtex feeding bags). Breastmilk should not be stored in hard plastic bottles; these bottles can cause the protein in breastmilk to break down. Breastmilk may be stored in the refrigerator for 48 hours or in the freezer compartment of a refrigerator for 2 weeks. To reheat frozen milk, thaw the milk in its container in a warm pan of water until warm. Discard milk that boils. Do not warm milk in a microwave.

A commercially prepared formula may be used as a substitute for breastmilk. Use of these supplements should be kept to a minimum during the first 6 weeks of nursing to ensure your breasts produce enough milk.

If you have any questions regarding breastmilk supplements, call your primary-care provider.

Assistance With Breast-Feeding. If you have any problems or questions about breast-feeding while you are in the hospital, ask a nursery nurse. If you have any questions or problems, or if you are told to take medication after you are discharged, call your primary-care provider during duty hours or the nursery during nonduty hours.

Weaning. Breast-feeding may be continued beyond your child's first birthday. You and your baby will determine how long to breast-feed. When you decide to stop breast-feeding, wean your child gradually. If you are weaning the baby to a bottle, start by substituting one bottle-feeding for a breast-feeding every day for a week. During the second week, substitute another feeding about 12 hours from the first substituted feeding. In the third week, substitute a third feeding. Continue this process until the child takes all of the feedings from a bottle. Your breasts will gradually diminish their milk supply, and you will have no unnecessary swelling. Your baby will also be happier.

FORMULA FEEDING

If breast-feeding is not right for you and your baby, your baby will thrive on commercially prepared formula. You can give your baby all the love, warmth, and closeness that a breast-fed baby experiences by holding, cuddling, and talking to your baby during each feeding. Do not prop the bottle for your baby to drink. Your baby will miss the holding and cuddling and may swallow more air, giving the child painful gas in his or her tummy. Small, formula-fed babies should be burped after drinking every ½ to 1 ounce of formula; older babies should be burped after drinking every 2 to 4 ounces.

Give your baby only iron-fortified formula during the first year of life. Commercially available baby formula provides the vitamins your baby needs. Do not use condensed, evaporated, or powdered milk.

Use a formula type that is most convenient and economical for you. Formula preparation types are ready-to-feed, concentrate, and powder. Prepare the formula according to the directions on the label. Prepared formula may be stored in the refrigerator for 48 hours. Discard formula left over from a feeding. Do not store leftover formula in the refrigerator for the next feeding, as it will harbor bacteria. Do not force your baby to drink an entire bottle of formula if the child does not want it. During the feeding, hold your baby in a semi-upright position so that the child's head is higher than his or her stomach. Never prop a baby's bottle. Feeding a baby while he or she is lying flat can make the child more likely to get ear infections.

Give your baby formula warmed to room temperature. Do not let prepared formula stand at room temperature for more than 2 hours. Once a baby drinks from a bottle, do not return it to the refrigerator or try to keep it at room temperature for more than an hour. Bacteria from the baby's mouth will sour and spoil the formula. If you warm the bottle, shake it to check the temperature of the formula before feeding it to your baby. Use a commercial bottle warmer or warm the formula under warm flowing tap water. Never warm your baby's bottle in the microwave. Pockets of scalding formula may form and severely burn your baby's mouth and throat.

Women, Infants, and Children (WIC) Overseas Program. WIC offers food to eligible expectant and breast-feeding mothers, as well as food or formula to eligible infants and children. The local WIC office may be contacted for information.

Schedule and Amount. A small baby will probably take 2 to 4 ounces of formula every 3 to 4 hours. Give the child 24 to 26 ounces of formula in a 24-hour period. An older baby may take 24 to 32 ounces in a 24-hour period. A baby who takes more than 32 ounces of formula may gain too much weight. Consult your physician if your baby is taking less than 18 ounces or more than 32 ounces of formula per day.

Preparing the Formula. Measure the exact amounts of formula and water. If you add too much water, your baby may become malnourished. If you do not add enough water, your baby may get an upset stomach. You can use tap water from approved sources. It is not necessary to boil the water if it is from an approved water source. If the water is safe for you to drink, it is safe for your baby. Bottled, distilled water is safe to use and is very handy for traveling. You can buy bottled, distilled water at the commissary. Only add cereals to a bottle of formula when directed by your physician.

Sterilizing and Caring for Equipment. Bottles do not need to be sterilized if they are rinsed in hot, soapy water. Use a bottle and a nipple brush to clean the insides of the bottles and nipples. You may wash bottles and nipples in a dishwasher.

Nipples. Nipple holes should be of adequate size for your baby to suck easily. When the nipple hole is the right size, warm milk will drip easily through it without forming a stream of formula. If the nipple hole is too small, your baby may get tired of sucking or may suck large amounts of air into his or her stomach. If the hole is too large, your baby will get too much formula too fast.

Nipple holes may become gummy. If this happens, put the nipples in a pan of water, add a pinch of salt, and boil the nipples for a few minutes. You may want to replace gummy nipples.

Pacifiers. Babies who are fussy or who chew on their fists are not necessarily hungry. Babies often need to suck. A pacifier may satisfy a sucking need. Do not use a pacifier as an all-purpose calming agent. Never use bottle nipples as pacifiers; the child can swallow too much air.

Water. Breast-feedings or formulas usually provide enough fluid for the child.

FEEDING-RELATED PROBLEMS

Burping. Burping your baby helps to remove air the baby has swallowed. Even if you feed your baby properly, both bottle- and breast-fed babies will swallow some air. The best way to release this air is to burp the baby. Hold the baby upright over your shoulder and pat or rub the child's back gently until he or she burps.

You can also place the baby in a sitting position (leaning slightly forward, supporting the head and chin with your hand) and rub his or her back. Younger infants are often difficult to burp, but do not let that discourage you. Sometimes your baby will not need to burp. Do not try to force the child to burp.

Generally, breast-fed babies should be burped between feeding on each breast and at the end of the feeding. It is not necessary to interrupt a feeding to burp your baby, but try to burp the baby at least after each feeding. After burping, put your baby in a crib on his or her back. (Sleeping on the stomach greatly increases the chance of sudden infant death syndrome (SIDS).) Most babies spit up after feeding. Do not be concerned unless the baby is vomiting forcefully or the baby is losing weight. Avoid creating excessive physical motion or exercise for your baby after feedings. If you have questions or are concerned, call your primary-care provider.

Spitting Up. Children commonly spit up or vomit. Some babies spit up more often than others. Spitting up occasionally is no cause for alarm. If your baby spits up through most of the feedings or often, call your primary-care provider.

Frequent burping decreases vomiting and gas problems and helps the baby sleep longer between feedings. Avoid bouncing games after a feeding.

Hiccups. Hiccups are common and frequently occur. Hiccups are not harmful. Give your child several swallows of liquid to help his or her hiccups settle.

SOLID FOOD

When can a baby begin eating solid food? Most authorities believe there is no rush for a baby to begin eating solid food. A baby needs only formula or breastmilk during the first 4 to 6 months of life for normal growth and development. Each baby has a distinct appetite. What foods one baby prefers, another may not. You will receive more information about feedings at your well-baby checkups.

Newborn to 3 Months. Generally babies do not require any solid food during their first 3 months.

- **Vitamins and Iron Supplements.** Ask your doctor about giving your baby vitamin or iron supplements.

- **Cereal.** It is not necessary to give a child cereal during the child's first 3 to 4 months of life. Parents certainly should not feed cereal to babies younger than 6 weeks. Some mothers report that babies fed cereal at night sleep longer; however, studies do not support this. To feed a baby cereal, mix rice cereal or oatmeal with formula, breastmilk, or water and feed the mixture to the baby with a spoon. Start with a small amount of cereal (1 teaspoon) and gradually increase the amount of cereal with each feeding.

- **Bottle Snacks.** It is not necessary to add cereal to bottles unless directed to do so by your primary-care provider.

Babies 4 to 12 Months. Most of the baby's nutritional needs are met by breastmilk or formula during the first 4 to 6 months of life. This is also the time when most babies can begin eating solid food.

- The following guidelines should help you determine how to begin your child on solid food:

    - Introduce your baby to solid food slowly so that the child can get used to the new tastes and textures. Give solid food from a spoon rather than putting it in a bottle or using a "feeder." Spoon-feeding may be frustrating at first, as most babies push out the food with their tongue. "Recycle" the food and, in a short time, the baby will learn to accept food from the spoon.

    - Offer solid food at the beginning of feeding just before giving formula or breastmilk. Babies usually will take new food better when they are hungry. Very hungry babies, however, may require part of the formula first, then the solid food, then the remainder of the formula.

    - Introduce one new food at a time and wait at least 1 week before trying the next new food. Babies occasionally develop rashes or stomachaches from certain foods. By offering one new food each week, you will know which food is causing the problem. Reactions to food are usually temporary. Try a problem food again in a month to see if the baby can then tolerate the new food.

    - Offer your baby a small portion of a new food. A few teaspoons are enough to start. The amount should be increased slowly so you can see that the baby is taking the new food without adverse effects.

    - Warm the food slightly--most babies accept food at room temperature. If you use commercially prepared baby food, pour a small amount of the food into a bowl and put the jar with the remainder of the food in the refrigerator. Discard any food left in the bowl. Once a jar has been opened, the food is generally good for 3 or 4 days if kept refrigerated. Discard food remaining after 3 or 4 days.

Home-Prepared Foods. Babies do not need to begin eating solid food in the form of commercially prepared baby food. There is nothing special in commercially prepared foods that makes them better than foods you can prepare at home. Commercially prepared baby foods are convenient but expensive. Home-cooked foods are easy and inexpensive. Use the following guidance to prepare baby food:

- Do not add salt or spices; they may make your baby uncomfortable or gassy.

- Use only fresh or frozen vegetables. Canned vegetables have too much salt. Use canned fruit in light syrup, or steamed or fresh fruit that can be mashed.

- Use a fork, a blender, or a food grinder to puree the food. Make sure there are no large pieces of food in the mixture that might cause your baby to choke. After boiling the vegetables, add a small amount of the water in which the vegetables were boiled to the food to make it easier to puree. Nutrients are in this water. Steam vegetables if possible.
- Store the home-prepared food the same way you would store commercial baby food. After you prepare the food, you can pour the mixture into an ice-cube tray. Cover the tray with a plastic bag to prevent freezer burn and store the tray in the freezer. Later, you can "pop out" a cube of the food, thaw it, and have a small portion of food ready for your baby to eat. Babies should begin eating solid food in the following order:
    - **Cereal.** The first solid food babies should eat is rice cereal. Rice cereal is smooth, bland, and accepted by most babies. Powdered cereal is better than jar cereal. Cereal can be mixed with breastmilk, formula, or water. Mix 1 to 2 tablespoons of cereal with 2 to 3 ounces of breastmilk, formula, or water to give the cereal a pea-soup consistency. Offer the cereal to your baby once a day for about 2 weeks, then try a new cereal. For the next 2 weeks, offer the cereal twice a day. Avoid wheat, mixed, or high-protein cereal until the baby is at least 6 months old.
    - **Vegetables.** After 4 weeks of feeding your baby cereal, try feeding the child vegetables. Initially, try yellow vegetables in small amounts (a few tablespoons) once a day for about 2 weeks. After 2 weeks, you can give the baby vegetables twice a day, while also giving cereal. This schedule will make a three-meal-a-day diet for the next 2 weeks.
    - **Fruit.** Most babies like fruit. Fruit may be given once a day for most babies. Because they are sweet, some babies learn to eat fruits and refuse vegetables. Try to start fruit after working through vegetables.
    - **Meat.** Babies usually start eating meat when they are 8 to 9 months old. Follow the same routine (amount and time) to introduce the baby to meat that you used for cereals and vegetables. Babies tolerate most meats. Once the baby is fully introduced to meat, you may follow the daily menu below:

        Breakfast: Cereal
        Lunch: Vegetable/Meat
        Dinner: Vegetable/Meat

Junior Food. Junior food is commercially prepared baby food that has more texture and substance than pureed food. Junior food is usually introduced a few months after strained foods are introduced. Babies who are ready for junior food can also eat table foods that are mashed up well with a fork.

Finger Food. When babies are about 7 months old, most of them enjoy holding food and putting it in their mouths. Small, cut-up cooked vegetables or meats are acceptable. Crackers and hard toast are also good. Do not let the baby have large chunks of these foods, as they can cause the baby to choke.

Juices. Children 4 months old generally can begin drinking juice. Use juice as a between-meal drink, not as a substitute for the baby's formula or breastmilk. Some babies will actually lose weight if they fill up on juice and do not take enough formula or milk.

Solid Food for Babies on Special Formula. If your doctor has placed your baby on a special formula, consider your child's needs when preparing solid food. If your baby is on a soy formula, avoid preparing solid food that contains milk (such as creamed vegetables, baby dinners, and pudding). Otherwise, follow the routine for solid food described above. If you have any questions about solid food for children with special dietary needs, contact your primary-care provider.

Foods to Avoid. The foods listed below often disagree with young babies. Avoid these foods until the baby is at least 9 months old:

- Wheat cereal (mixed and high-protein).
- Tomatoes.
- High-protein foods.
- Citrus fruits and juices.

Do not give your baby chocolate, egg whites, honey, nuts, or syrup until the child is at least 1 year old.

Heating Baby Food in Microwave Ovens. Several varieties of baby food cannot be heated in a microwave oven. Many baby-food labels remind parents not to heat the food in a microwave oven. If you use a microwave oven, follow these tips, prepared by the Gerber Baby Food Research Staff, for heating baby food in a microwave oven:

- Do not heat the following baby foods in microwave ovens: egg yolks, high-meat dinners, meat or poultry sticks, plain meats, and poultry.

- Microwaved baby food may splatter and cause burns. Microwave ovens heat baby food unevenly, which may cause the food to explode. Droplets of water in the food heat faster than the dense protein and fat particles. The water turns to steam in small pockets. Shaking the dish when you remove it from the microwave oven or just stirring the product with a spoon can cause a hot splatter or scald. It is best to stir the food after it has cooled. If you must heat baby food in a microwave, use caution and be sure to test the food's temperature before feeding it to your baby.

- To heat baby food in a microwave oven, first remove the cap from the jar. Place the jar on a plate in the oven. Start heating the food at the lowest level of heat. Test the food frequently until it reaches feeding temperature. You may want to record the cooking time and the temperature setting for future reference. Plain and mixed food combinations have a natural water content that heat more evenly without steam pockets. Avoid overheating the food. Consult the manufacturer's instruction booklet or your dealer before heating baby food in a microwave oven.

GENERAL CARE

Umbilical Cord. The umbilical cord usually begins drying up a few days after the baby is born. The cord will drop off between 5 and 21 days after birth. Keep the area around the base of the cord clean and dry. Apply a small amount of rubbing alcohol to the base of the cord (keeping it off the skin) two or three times a day with a cotton swab. Thoroughly clean the entire umbilical area each time. Continue cleaning this area for several days after the cord falls off. There occasionally is bloody discharge from the navel just before and after the cord separates. Clean the discharge with alcohol. Do not be alarmed if the discharges continue for 1 or 2 days. Try cleaning with water. If the discharges continue after 2 days, contact your primary-care provider. If the skin in the navel area becomes red or tender, seek emergency care immediately. You may bathe the baby after the navel is completely healed (usually 1 or 2 days after the cord falls off).

Water. You can offer older babies water to drink any time. Except during the warm months, babies do not need extra water; water is in formula and breastmilk. You may use water to calm an infant who is fussing until his or her feeding is due. Do not give an infant less than 2 months old daily water without consulting your primary-care provider.

Bathing and Skin Care. When the umbilical cord has fallen off and, for circumcised boys, the circumcision is healed (usually 6 to 12 days after circumcision), you may bathe your baby in a regular tub. Until the umbilical cord is off and the circumcision is healed, sponge-bathe the child with soap and water. Only baby products are suitable for your baby's skin. Be gentle during the baby's first bath experiences. Ensure the water is tepid and comfortable. Do not splash water on the baby's face. Soap dries the skin. You can bathe the baby with just water. For the first few weeks it is not necessary to use soap on the baby's face. Wash the baby's hair twice a week with baby shampoo. If you use powder, always put it on your hand away from the baby and apply to skin away from the face. If the baby accidentally breathes talc, contact your primary-care provider. Do not use oils and lotions on babies. They are not necessary. The drier the baby's skin, the less often you should bathe the child with soap.

Diaper Rash. For "ordinary" contact diaper rash, use mild, commercial diaper ointments or plain petroleum jelly. If the rash does not improve, consult your physician. To prevent diaper rash, change your baby's diaper as soon as possible after each bowel movement or wetting. Wash the baby's buttocks and genital area with a soft cloth and mild soap and water. Rinse with warm water. Pat the area dry with a clean, soft cloth. Avoid using plastic pants. You may use gentle baby wipes if they don't give the baby a rash.

Bowels. Babies eventually establish their own bowel patterns. Some infants have one bowel movement every 1 to 3 days while others have a bowel movement 6 to 8 times each day. Stools are normal if they are not very hard or if they are very watery. Occasionally, stools have a green color. This situation is usually temporary and is not serious. Most babies occasionally grunt, groan, cry, and get red in the face when having a bowel movement. This is also normal. Stools from breast-fed babies are loose and golden seedy-yellow. Sometimes they are passed after every feeding; but completely breast-fed babies may have a bowel movement only once a week. Stools from babies who take regular formula (high in casein, such as Similac or Enfamil with iron) are usually formed and brown, and occur from several times a day to once every 2 or 3 days. Infants in the first weeks of life frequently cry and strain to pass soft stools. This is normal and does not indicate constipation. If you are concerned about constipation in your infant, call your primary-care provider. Never use corn syrup or honey to soften stools or dilute formulas. Do not change to a low-iron formula without speaking with your primary-care provider first.

Dressing the Baby. Dress your baby according to the weather. In very hot weather, you may want to dress the baby only in diapers and a light shirt. Most mothers overdress their babies, which is much worse than under-dressing them. Do not dress the baby in rubber or plastic pants when the baby is sleeping or if the baby has diaper rash. Rubber and plastic pants can irritate diaper rash. You can tell whether or not your baby is under- or overdressed by touching your baby's skin. If the skin is cold, the child needs heavier clothing. If the skin is hot, the child needs lighter clothing. The child's skin should feel warm.

Sleeping Position. Recent studies in several countries have clearly shown a decreased risk of SIDS in infants who sleep on their back. All infants should be placed on their back to sleep. Older infants will change their position when they can roll over on their own. If your infant often vomits, consult your physician for guidance on the safest sleeping position. In addition, remove all soft material from the inside of the crib.

Circumcision. Circumcision is an irreversible surgical procedure to remove some of the foreskin from a penis. Scientific studies show very few medical benefits of circumcision. However, these benefits are not sufficient for the American Academy of Pediatrics to recommend that all infant boys be circumcised. Since circumcision is not essential to a child's heath, parents should choose what is best for their child by looking at the benefits and risks of this procedure. One circumcision procedure for newborn boys and for boys a few weeks old requires attaching a plastic ring, called a Plastibell, to the child's penis. A dark brown or black ring encircling the plastic rim is perfectly natural. The ring will disappear when the rim of skin drops off, leaving a clean, well-healed line of excision. The plastic ring and the rim of skin usually drop off 6 to 12 days after the circumcision. Special dressings are not required and there are no special requirements for bathing and diapering the child after the foreskin has fallen off. Notify your physician immediately if you notice any unusual bleeding or swelling of the penis, if the plastic ring does not fall off within 12 days, or if the ring has slipped onto the shaft of the penis. The penis should never be painful when touched.

There are two other procedures that may be used by your physician. Both remove the foreskin, but do not leave any equipment. These procedures are the Gomco and the Mogen. Babies who have either of these procedures may need to have petroleum jelly or petrolatum gauze placed on the incision area for up to 24 hours after the procedure is done. Notify your physician immediately if you notice any unusual bleeding or swelling of the penis. The penis should never be painful when touched.

Toddlers and older children must be circumcised using surgical procedures with general anesthesia.

If you decide not to have your baby circumcised, there is no need to pull the foreskin down forcefully. The foreskin will gradually separate and can be easily retracted when the boy is 3 to 5 years old. After the foreskin separates, pull the foreskin back each time you bathe the boy and cleanse the penis thoroughly. Return the foreskin to its normal position if it does not return automatically after the cleaning. If you have difficulty pulling the foreskin back, ask your primary-care provider for assistance.

Labia. If you have a little girl, gently spread her labia apart and clean, wiping from the front to back with plain warm water and cotton. Use a clean cotton ball for each wipe. It is not uncommon for baby girls to have a small amount of mucus or a bloody discharge the first week after birth. Remove any stool from the labia after each bowel movement. Never bathe your little girl in bubble bath; it irritates the labia and may cause urinary tract irritation. Occasionally a little girl's labia become stuck together and require treatment prescribed by your primary-care provider to be safely separated.

TEETH

Children have two sets of teeth. The first set is temporary and is called deciduous or baby teeth. Nature eventually replaces these with permanent teeth. Some of the deciduous teeth begin calcification, and the crowns form as early as 3 or 4 months before the baby is born. Expectant mothers should consult their physician regarding a well-balanced diet to enable the baby's temporary teeth to form properly.

Teething. Teething begins when the infant first begins drooling, which is at about 6 weeks to 3 months. The discomfort of teething varies from child to child. Most children will be fussy and eat poorly when teething. A teething ring may help lessen the child's irritation. If the child is extremely fussy and cannot sleep, give the child the appropriate dose of Tylenol. Rubbing a clean cloth soaked in ice water on the gums may temporarily relieve the pain. You may also apply teething ointments to the gums.

Temporary Teeth. The 20 deciduous teeth break through the gums about 6 to 10 months after birth. These teeth continue growing until the child is about 30 months old. Babies' teeth appear in groups, with intervals between each group. The time and order of teething varies. The time or order teeth appear has no effect on the character of the teeth. The time teething begins is somewhat hereditary. In some families, teething begins earlier than in others.

Beware of "nursing-bottle tooth decay." Putting babies to bed with a bottle of milk, juice, or other liquid that contains sugar can cause severe tooth decay. Nursing-bottle tooth decay occurs when the liquid containing sugar coats the teeth. Because sleeping babies produce less saliva to wash the liquids away, and because of the extended time these teeth are exposed to a constant sugar attack, the rate of decay is very rapid. Do not put your baby to bed with a bottle. Baby teeth should last until they fall out naturally and are replaced by permanent teeth. Baby teeth are important for chewing food, for forming sounds for speech, and for making a pathway for permanent teeth. If a baby tooth has some decay, have a dentist check it to avoid greater problems later. Infected baby teeth are painful and can affect the new permanent teeth beneath.

When the first baby teeth break through the gums, start taking care of them. A washcloth with cold water rubbed over the teeth and gums will remove the bacteria that, if left on the teeth, will harden and cause decay. The hardened bacterium is called plaque.

Permanent Teeth. When your child is about 6 years old, permanent teeth begin to appear. The first of the permanent teeth, the 6-year molars, do not replace temporary teeth. These molars grow just behind the second molars of the temporary teeth. By this time, the jaw has expanded enough to give these molars the space necessary to grow.

When your child is 7 or 8 years old, permanent teeth will begin to replace the temporary teeth. Permanent incisors replace temporary incisors. When the child is 9 or 10 years old, the permanent bicuspids will replace the temporary molars. In children 11 years old, the permanent bicuspids replace temporary cuspids. In children 12 years old, the four second molars appear, completing the permanent dentition or development and cutting of teeth. The remaining four molars (the wisdom teeth) do not grow in until the child is 17 to 25 years old. Temporary teeth are sometimes so firm that they are not loose when the permanent teeth are ready to appear. The temporary teeth can force the permanent teeth out at the side of the gums, causing serious irregularities to the teeth and the jaws. These irregularities disfigure the child's facial outline and expression. If these irregularities happen, take your child to the dentist early.

As permanent teeth appear, parents should help their children avoid candy, soft drinks, gum, and other sweets. Eating sweets promotes tooth decay. Take your child to the dentist when the child is 1 year old, and regularly as the dentist requests after that. Ask your primary-care provider about extra fluoride (if fluoride is not added to your water supply) to prevent tooth decay.

When should children begin caring for their own teeth? Usually, children who can tie their own shoes have the physical ability to take care of their own teeth. You must brush your child's teeth until your child is old enough to brush them. Let your child try, however, to use the brush at an early age so that the child will be accustomed to the feel of the toothbrush. Let your child start brushing, then you can finish the job.

EYES

Your baby's eyes may have some white or yellow discharge caused by irritation from the medicine that was put in them at birth. The discharge should clear up within 5 or 6 days. If the discharge gets worse or lasts longer than a week, promptly seek medical advice.

After 6 weeks to 3 months, your baby's eyes should look straight at you when the child is alert. One eye may turn slightly in or out when the child is very tired, but both eyes should work together most of the time. If not, seek medical advice during your baby's next medical appointment.

BIRTH REGISTRATION

Parents who give birth overseas must register the baby's birth with the appropriate U.S. or host-nation authorities (in some cases, with both). The birth-registration documents the baby's citizenship and enables the baby to get a passport. A baby must have a passport to travel within Europe or to enter the United States.

To begin processing a baby's birth registration, take your baby and the required documents and fees to the servicing personnel detachment (PD) within 30 days after the baby's birth. You must bring your baby with you when you take the oath affirming the truthfulness of statements on the birth report. If both parents are U.S. citizens, the parent submitting evidence of citizenship (preferably the mother) must take the oath and sign the form. If only one parent is a U.S. citizen, that parent will take the oath. When neither parent is a U.S. citizen, servicing PD personnel will refer the parents to the servicing legal assistance office. Birth-registration requirements apply to babies born to people (including U.S. Forces active duty soldiers) in U.S. Forces medical treatment facilities and civilian medical facilities.

Parents can get more information about birth-registration requirements and procedures from the U.S. Forces medical treatment facility or the sponsor's servicing PD.

SECTION III
COMMON PEDIATRIC PROBLEMS

DIARRHEA

If your child or toddler has diarrhea (loose, frequent, watery stools), feed him or her toast, Jell-O, crackers, slightly green bananas, and rice-cereal powder mixed with water or mashed bananas. These foods tend to make stools more solid. Do not stop breast-feeding or providing formula during diarrhea. Breastmilk and formula have been shown to speed the healing of the intestine, reduce weight loss, and shorten the course of the diarrhea. Give oral rehydration fluids (such as Kaolectrolyte, Pediatlyte, or Rehydralyte) to make up the additional fluid lost through frequent watery stools. Even though it may seem like your child has more bowel movements when you feed him or her, feeding is important to keep up with the fluid losses. Take your child to a doctor if the child is less than 1 year old and if any of the following problems occur during diarrhea:

- The above diet does not improve the diarrhea in 3 days.
- The child has a fever of 101^{o}F or higher.
- The diarrhea occurs suddenly and is frequent and very forceful.
- You see blood or mucus in the stool.
- The child shows signs of dehydration (fluid loss):
    - No tears when crying.
    - The inside of the mouth between the cheek and gum feels dry to your clean finger.
    - No urination for periods of 8 hours or longer, or urination only in small amounts.
    - The fontanel (soft spot on the head) is sunken while lying down.
    - Irritability, unusual quietness, or listlessness.

If you feel your child is showing signs of dehydration, go to the nearest emergency room for an evaluation.

DIARRHEA AND VOMITING

Diarrhea and vomiting usually stop after a short time. When either occurs, do not feed the baby large volumes; they may cause further vomiting. The key to treatment is to allow the baby's stomach to work as little as possible so that it and the intestines can devote more time to fighting the infection. Use the following general guidelines for mild or moderate cases of vomiting or diarrhea (if you have specific questions, ask your primary-care provider):

- Give the child only small amounts (one teaspoon every 2 or 3 minutes) of oral rehydration fluids (such as Kaolectrolyte, Pedialyte, or Rehydralyte) for at least 8 hours (but no longer than 48 hours) until the vomiting subsides. If this takes longer than 2 days, consult your physician.
- When the vomiting subsides, follow the advice in the diarrhea section above.

Remember that the major danger to children from vomiting is dehydration. Dehydration occurs when the body loses more fluids from the vomiting or diarrhea than the child can take in. If your child cannot tolerate a clear liquid diet, or if the vomiting and diarrhea get worse, bring the child to your primary-care provider or the nearest emergency room.

Other helpful hints:

- Give the child small amounts of fluids frequently, such as 1 or 2 teaspoons every few minutes.
- Give the child liquids at room temperature.

- Most anti-diarrhea medications will not significantly help children overcome diarrhea and are not recommended for children less than 6 years old. The diet outlined above is the best treatment for diarrhea.

FEVER

Fever is one of the most common reasons parents seek pediatric medical care. Twenty to 30 percent of calls and visits to physicians or emergency rooms involve fever as one of the child's symptoms. Most parents worry that the fever will cause serious harm, such as brain damage. Fever is the body's way of fighting infection and is rarely harmful. Treatment occasionally is not necessary.

The body's average temperature is 98.6°F orally, with normal fluctuations during the day from a low of 97.0°F in the morning to a high of 100.4°F in the late afternoon. Exercise, warm clothing, warm food or drink, and hot weather can cause temperatures to rise slightly. Fever is a rectal temperature above 100.4°F. The degree of fever does not always relate to the seriousness of the illness. How sick a child acts is what counts. Your physician is much more concerned about an ill-appearing child without a fever than a happy, playful child with a high fever.

If the baby is shivering or feels cold, its temperature is rising. A flushed appearance means that the fever has peaked. Sweating means that the temperature is decreasing or "breaking."

Fever is the body's response to infections, either bacterial or viral. Fever alone is not dangerous. Serious causes of fever, such as meningitis, can be dangerous, but are usually combined with other symptoms that may alert a parent to serious infections. Remember the following facts about temperatures:

- A child under 3 months old who has a rectal temperature of 100.4°F or greater should be seen by a physician immediately.
- A fever is treated so that the child feels better, not because the fever is dangerous.
- A fever is only a guideline to determine how much evaluation a child needs. The child's activity level, eating habits, and the way the child looks are more important than the child's temperature in determining the severity of an illness.
- A rectal temperature of 101°F to 102°F in children over 3 months old is acceptable as long as the child is acting normally and the fever does not last longer than 72 hours.
- A child under 36 months old with a rectal temperature over 102°F should probably be seen by a physician within 24 hours.
- A physician should see any child who has a fever that lasts longer than 72 hours.
- A child who is unresponsive, who totally stops eating or drinking, or who has difficulty breathing, regardless of his or her temperature, needs to be taken to the nearest emergency medical facility as soon as possible.
- Do not be afraid to ask your primary-care provider questions about fever and your child's illness at your next visit or over the telephone.
- Do not bathe the child in tepid water without using Tylenol (with the exception of a child suffering from heat exhaustion). Tepid baths lower body temperature without resetting the biologic thermometer; the temperature rapidly elevates again immediately after the bath. Some physicians think giving tepid baths without using Tylenol can increase the chances of the child suffering a febrile seizure.
- Do not give aspirin to a child under 18 years of age. Aspirin may increase the risk of Reyes Syndrome.

Axillary temperatures (temperatures taken from the armpit) are adequate to screen for fever. Checking a rectal temperature can be used to confirm an axillary temperature. The thermometer should be left in place until the value stops rising (approximately 2 minutes for the rectum, 7 minutes for a dry armpit, or 5 to 7 minutes in the mouth).

Fevers do not climb relentlessly upward. Most children have fevers no higher than 104°F. Brain damage cannot occur until the fever reaches at least 107°F. About 4 percent of children with a fever will also have convulsions (febrile seizures). Convulsions are scary, but those solely from fevers are harmless. Any child with a first-time febrile seizure should be seen by a physician.

Most physicians consider high fever to be a rectal temperature of 104°F. Only 5 percent of feverish children have high fevers. Temperatures this high show an increased likelihood of bacteria in the blood stream. Side effects of fever are generally harmless and treatable. Side effects include mild dehydration, discomfort, transient delirium, and simple convulsions. If your child has a fever, encourage him or her to drink fluids, but do not force the child to drink. Dress the child in a minimum of clothing so he or she can lose body heat through the skin.

If your child has a fever, use these guidelines to determine whether or not to call your primary-care provider:

- Seek medical care immediately if your child is less than 3 months old and--
    - Has a rectal temperature 100.4°F or greater.
    - Is crying inconsolably or is difficult to awaken.
    - Has a seizure.
    - Has purple spots on the skin.
    - Is acting very sick.
    - Has difficulty breathing, even after his or her nose is cleared.
    - Has an underlying risk factor for serious infection (such as sickle-cell disease).
- Seek medical care within 24 hours if your child is between 3 to 36 months and--
    - Has fever higher than 102°F.
    - Has had the fever for longer than 72 hours.
    - Has a fever that had gone away for more than 24 hours, then returned.

INSECT BITES AND BEE STINGS

Insects often bite children. Mosquito bites are the most common. Mosquito bites, even if they are numerous, cause little difficulty other than local itching and small red swellings. Parents may relieve the itching by applying calamine lotion. Keep the bite clean and avoid letting your child scratch those areas. No additional medical treatment is necessary.

Stinging insects (bees, hornets, wasps, and yellow jackets) can present two different kinds of problems: a local reaction to the sting and an allergic reaction to the sting.

Local Reaction. If the insect's stinger is still present after a sting, remove the stinger by scraping it with your fingernail. Do not pull the stinger out. Pain, redness, and swelling of the stung area is immediate and may worsen over the first 24 to 48 hours. The local swelling may be great enough, for example, to cause a whole foot or hand to swell. As long as the reaction is confined to the general area that was stung, no allergy to the sting has occurred. Here are some ways to treat stings:

- Apply ice to the stung area as soon as possible and periodically for the next several hours to reduce swelling.
- Apply a paste made from baking soda and water or Solarcaine to the stung area to soothe the pain.
- Take appropriate doses of Motrin or Tylenol to relieve the pain.
- Apply Calamine Lotion or 1-percent Hydrocortisone Cream to reduce itching and skin reaction.

Bee stings rarely become infected. Take the child to a physician if--

- Fever develops.
- Pus develops where the sting occurred.

- Red streaks develop where the sting occurred.

Allergic Reaction. Allergic reactions to stings are far less common than local reactions. If a child is allergic to a sting, the sting will cause a local reaction and the following general symptoms will occur:

- Generalized hives (raised pale, pink, irregular welts that come and go) on the skin.
- Wheezing in the chest.
- Swelling of the face and eyes.
- Difficulty breathing.

Children experiencing these symptoms are having a significant allergic reaction and must be seen by a physician immediately.

ATOPIC DERMATITIS (ECZEMA)

Atopic dermatitis is an intensely itchy, chronic condition of dry skin. It is the most common type of childhood eczema and is also seen in characteristic patterns in adolescents and adults. No one knows what causes atopic dermatitis. Most children outgrow atopic dermatitis, but some people continue to have the disease most of their lives. There is no way to predict who will outgrow atopic dermatitis.

Approximately 70 percent of patients with atopic dermatitis have a family history of allergies. About 3 percent of infants have some evidence of atopic dermatitis during the first few months of life. About 50 percent of children with atopic dermatitis develop either rhinitis or asthma. Severe, easily triggered itching is the most common symptom of atopic dermatitis. Many of the clinical signs physicians see are caused by scratching and rubbing the skin.

Caring for the Atopic Child. The following guidance will help your atopic child be more comfortable:

- Avoid putting wool next to the skin. Clothing close to the skin should be smooth (such as chamois, cotton, gabardine, linen, poplin, suede, and synthetic fibers (orlon and nylon)). Wash new clothing before allowing your child to wear it.
- Avoid using feather pillows. Foam-rubber pillows or pillows covered with special fabrics should be used. Cover woolen blankets with a sheet. Foam or horsehair mattresses may be used. Avoid kapok mattresses. All other types of mattresses should be sealed in rubberized cloth.
- Keep furniture as plain as possible. Avoid dust-gathering draperies and carpets. Keep rooms as bare as possible with washable walls and floors. Furniture should be made of plain wood. Avoid upholstered furniture.
- Avoid fuzzy or woolen toys like teddy bears. Toys made of paper, plastic, rubber, or wood are acceptable.
- If the child has proven allergies, do not allow birds, cats, or dogs in the house. Fish are acceptable.
- Protect the child from exposure to dust as much as possible.
- Do not allow the child to sweat excessively. Bathing in sea (salt) water is very beneficial.
- Reduce situations that may cause tension and nervous excitement. Tension and nervous excitement will cause the child to scratch and itch.
- Avoid contact with persons with herpes simplex lesions (cold sores, shingles).
- Consult a doctor or pharmacist about the mildest or least-irritating soaps that may be used to wash the skin when it is dirty. Avoid overusing soap.
- Discuss with your child's physician when to bathe the baby. Some children do better with few baths or showers (once a week), while others do better with daily, long baths.

- Be aware that certain foods occasionally worsen atopic dermatitis. Skin tests for foods do not determine which foods will have this effect. If you notice that eating a particular food regularly makes the child's rash worse, discontinue serving that food for 1 month. Then let your child try eating the food again. Do not place the child on a strict diet unless your doctor advises it.

- Use a room or house humidifier. A humidifier may be beneficial, especially in winter.

- Rub on a generous amount of moisturizer (Aquaphor, Eucerin, Moisturel) while the child's skin is still wet and pat the skin dry. Do not rub the skin dry.

Despite taking precautions, there will still be periods of flare-ups. Take your child to your primary-care provider when flare-ups occur.

SPEECH AND LANGUAGE DEVELOPMENT

When babies begin to walk, they explore a whole new world. Learning by seeing, hearing, and touching will begin to happen all at once. When children begin to stand and move around, they will see things they have never seen before. Your child will be eager to investigate and to learn names for everything. Many things will now be at eye level (for example, bookshelves, tabletops, television knobs). Your child will be seeing many more things and handling them if you let them. Parents should understand the importance of telling children the words that go with their new discoveries. Parents should talk about the color, feel, shape, size, sound, and taste of things with their children.

This helps to develop your child's thinking process. The ability to speak starts with your child's first words. Although your child probably says a few meaningful words, he or she needs your help to learn more. Give your child a new word or a short phrase that fits every new experience. Saying simple words or phrases when your child needs them will help him or her understand what is going on.

Your child may need to hear words again and again before he or she tries to imitate them. This is typical and should be expected. Children learn to understand words before they use them meaningfully. You will probably grow tired of repeating the words long before your child tires of listening, but your child needs to keep hearing them.

As children approach 18 months they should be able to say the names of several common objects. The words will not be perfect, but they will be close. Children may say "baw" for "ball," "poon" for spoon," and "tup" for "cup." They may suddenly begin to repeat too many of the things they hear. This is not a sign that the children no longer need help in learning to talk. Imitation is a typical stage of speech and language development. Parrot-like imitation is fine for giving children practice in making speech sounds, but it teaches them very little about what the words mean or how to use them.

By the time children are 5 years old they can say many words in many different ways. They can use and know the differences between words such as "big," "small," "littlest," "tiny," "many," "more," "none," "yesterday," "today," and "tomorrow." They can tell you about animals that can hurt and animals that are fun. They know when something is upside down or inside out. They can often do special things, such as spell their own name and say the alphabet.

Suggested Activities. Parents should work at developing a child's imitation skills and forming a good emotional relationship. When a child is in his or her second year of life, these skills will have a great influence on the child's ability to learn to talk. You are the model of your child's speech and language; speaking slowly, clearly, and simply is important. If you want to understand how hard learning to talk is for your child, imagine yourself in a foreign country listening to a foreign language. First you would try to understand the meaning of those strange sounds. The foreigner to whom you are listening can help you understand by using as few words as possible and by adding plenty of gestures. If the foreigner pronounces the words clearly and slowly, you have an easier time repeating them. When the foreigner points to whatever he or she is talking about, the action helps you understand even faster. When you learn the words, you need to hear them many times before you feel comfortable using them. With this understanding in mind, try to remember these important rules:

- Use simple, clear, slow speech in a normal tone of voice when talking to your child.

- When you are going to do something new, talk about what you are going to do before you do it, while you are doing it, and when it is done.

- Begin by teaching words that are useful: body parts, clothing, family names, foods, toys.

- Make your child feel that he or she is part of what is going on, not just an observer.

- Talk with your child. Give your child a chance to add his or her contribution to the exchange, even if you do not understand it. Listen to what your child says. Make your child feel that what he or she says is important.

- When using new words, be sure the child can hear the words well and can see how you say the words.

- Do not expect or demand perfection.

Self-Talk. When your child is near, talk aloud about what you are doing, feeling, hearing, or seeing. This is called "self-talk." For example, as you hang the clothes, dust the furniture, make the bed, wash the car, or set the table, talk about what you are doing. Talk slowly and clearly, and use simple words and short phrases.

Parallel Talk. Parallel talk differs from self-talk in that you talk about what is happening to your child. Use words that describe what your child is doing, feeling, hearing, or seeing. This process gives your child words to think about while doing what you describe. Later the child will use these words to tell you about things that are happening to him or her.

Listening. Learning to listen is important, so work on this too. Your child needs help to understand all that he or she is hearing. Outdoors, try to make your child notice noises of engines running, trucks braking, dogs barking, leaves rustling, birds singing, and the wind blowing. Indoors, you and your child can hear doors closing, water running, someone walking, a mixer in the kitchen, the furnace starting, the clock ticking, the vacuum cleaner running, or the tea kettle whistling. You may already have called your child's attention to some of these sounds. Talk about those sounds and any others you think of, especially if your child asks about special sounds his or her toys make. Many activities will also help build listening skills. The following are examples of these activities:

- Give your child simple directions, such as "Bring me the ball." Each time, request a different object that is familiar to your child. Your child will be eager to show that he or she understands you. Ensure your child knows you are proud of what he or she is doing. Use parallel talk.

- Sing the tune "Here We Go Round the Mulberry Bush," adding your own lines. For example, sing "This is the way we wash our hands, so early in the morning." You can also use other short phrases such as "eat our soup," "comb our hair," and "brush our teeth." Show your child how to act out each new line. This exercise helps build your child's imitation skills and is fun.

- Play follow-the-leader. This game is very good to play with other children in the family. The children can line up and the leader can give directions, such as "pat your head," "clap your hands," or "go behind the chair." Even a 1-year old child can play this game.

- Encourage your child to play "ring-around-the-rosy." This is a good listening game. If there are older children, they can help teach the younger ones.

- Play "hide-and-seek" with your child. Hide-and-seek is a game that little children usually enjoy. Do not make the game too hard. Call to your child from your hiding place if the child takes too long to find you, or let a little of you show until your child becomes good at this game. This is another good time to use parallel talk as your child tries to find the people who are hiding.

- Let your child listen to people talk on the telephone. Let your child say a few words to the person on the line. Children this age are curious about voices on the telephone, but say very little until they become more familiar with the telephone.

- Read a story to your child every night, if not more often.

Below are some language and physical-skill activities expected of a typical 12- to 18-month-old child.

Can your child--

- Say four to six different words?

- Tell you what he or she wants by pointing and saying a few words?

- Understand words and phrases when gestures are used?

- Walk alone?
- Climb stairs on all fours without help?
- Recognize the names of most of the common objects in your home? To determine the answer to this question, put the words listed below in one or another of the blanks, one after the other, and see which words your child understands:

Where is the____? Show me the____? Give me the____?

apple	cat	door	table
ball	diaper	light	toy car
bed	dog	scissors	toy truck
bottle	doll	stove	window

- Point to the correct body part when you ask the following questions:

Where is your mouth?	Where is your foot?
Where is your eye?	Where is your leg?
Where is your arm?	Where are your fingers?
Where is your hand?	Where are your toes?

- Use the names of familiar things, such as book, cup, spoon, water, or ball?
- Use the word "no" a great deal?
- Say "hi" and "bye-bye" (or words that mean the same thing) at the appropriate occasion?
- Imitate the words you say in a parrot-like manner?
- Enjoy repeated rhythms, songs, and interesting sounds?
- Eat with a spoon?
- Stack three blocks?
- Take four to five blocks from a box?
- Try to catch and throw a ball?
- Turn the pages in a book, even though he or she usually turns more than one page at a time?
- Pull a toy while walking backwards?
- Climb onto an adult-size chair?
- Feed him- or herself, even though he or she spills the food?
- Walk upstairs while holding an adult's hand?
- Walk well enough to seldom fall?

After answering these questions, you may feel a bit concerned; but keep in mind that these questions represent only averages. Each child is different. There are many variations within the limits of what is considered typical. If, based on your answers to these questions, your child's development seems to be significantly behind his or her actual age, your child may need special attention. Early development intervention specialist (EDIS) personnel at your medical facility can evaluate your child's developmental status if your child is less than 36 months old. The Department of Defense Dependents Schools (DODDS) system will evaluate children 36 months old and older.

SECTION IV
PREVENTIVE PEDIATRICS

Pediatrics as a medical specialty began over 100 years ago in response to a realization that children's health problems are different from those of adults. Pediatrics has advanced and now also emphasizes illness prevention. The concept is to anticipate problems to prevent or minimize them. The result is a healthier and happier child. Parents must understand this concept, as they have the ultimate control of their children's destiny. As a parent, you are the most important link in the process of providing good health care to your child.

WHAT YOU NEED TO KNOW ABOUT IMMUNIZATIONS

Babies are immune to many diseases when they are born, but this immunity, which they receive from their mothers, wears off during their first year. Children must then develop their own immunity.

Immunizations help children develop strong, permanent defenses. Many dangerous childhood diseases exist that can cause illness, suffering, and death. Many of these diseases can be prevented with immunizations. Immunizing your child also keeps your child from spreading diseases to other children. Most of these illnesses are spread quickly, and younger children often cannot yet receive the immunizations your child can. If your child is ill, it puts these younger children at significant risk. Many of the countries where we are stationed have less-demanding immunization requirements than the United States. Therefore, the risk of a child being exposed to one of these preventable diseases is higher in the European region. This is a very important reason why all children should have their immunizations up-to-date.

Some vaccines have significant risks. However, vaccines are still one of our safest medicines. In recent years we have developed safer versions of vaccines or schedules for vaccines. The risk of the illness always outweighs the risk of injury from a vaccine.

Diphtheria, Tetanus, and Acellular Pertussis (DTaP). Before vaccines were available, thousands of people became ill with diphtheria and hundreds became ill with tetanus each year. Most children caught pertussis. These diseases can cause serious health problems. Your children must therefore be protected by vaccines.

Diphtheria can cause breathing difficulty, paralysis, or heart failure. About 10 percent of the people who get diphtheria die of it. Only a few cases of diphtheria were reported in the United States during the past few years, mostly because people have been immunized.

Tetanus (sometimes called lockjaw) can occur when the germ enters the body through a cut or wound. Tetanus makes a person unable to open his or her mouth or swallow and causes serious muscle spasms. People with tetanus usually require lengthy hospitalization. In the United States, tetanus kills 30 percent of the people who contract it. Since 1975, only 50 to 90 cases of tetanus have been reported each year.

Pertussis (sometimes called whooping cough) can be a mild or serious disease. Pertussis is easily passed from person to person. It can cause coughing and choking spells that make eating, drinking, or breathing difficult. The coughing can last several weeks. In recent years, as many as 4,200 cases of pertussis were reported each year in the United States. Many cases, especially those with less serious outbreaks, are not reported.

Pertussis is most dangerous to children who are less than 1 year old. Almost half of all babies who contract pertussis require hospitalization. Sixteen percent of babies with pertussis get pneumonia. Two percent suffer convulsions (seizures, fits, spasms, twitching, jerking, staring spells). Pertussis causes permanent brain damage or death in 1 out of every 200 babies who contract it. Serious illness is less likely in older children and adults. Usually, the vaccines for these three diseases are combined and given as one shot. This is called the DTaP vaccine. Children usually receive the first three DTaP shots by the age of 6 months. They receive a total of five before they reach the age of 7.

Receiving three or more DTaP shots prevents--

- 70 to 90 percent of children from getting pertussis. Immunized children are usually protected through the elementary-school years. Children who have had the DTaP immunization but still get pertussis usually have a milder illness than they would have had without the immunization.

- At least 85 percent of children from getting diphtheria for at least 10 years.

- At least 95 percent of children from getting tetanus for at least 10 years.

Most children have little or no negative reaction from the DTaP shot. Many have mild fever or soreness, swelling, and redness where the shot was given. These reactions usually are mild and last 1 or 2 days. Some children become cranky, drowsy, or do not want to eat. The high fever and seizure reactions previously associated with the pertussis vaccine are greatly reduced with the use of the acellular pertussis component found in DTaP.

Babies born under unclean conditions to women who have not been vaccinated for tetanus have an increased risk of getting tetanus. Pregnant women who have not been immunized should get the tetanus and diphtheria vaccination before the child is born.

Talk with the doctor or nurse who gives the shot about giving your child medicines or taking other measures to reduce fever and soreness caused by the vaccine.

Measles, Mumps, and Rubella (MMR). Before vaccines were available to protect against measles, mumps, and rubella, nearly everyone caught these diseases. The MMR vaccine has greatly reduced the number of people who get these illnesses.

Measles is a serious disease that is easily passed from person-to-person. Measles causes a high fever, a cough, and a rash that lasts for 1 to 2 weeks. In recent years, between 3,000 to 28,000 cases of measles were reported in the United States each year. Ten percent of the children who get measles also develop an ear infection or pneumonia. One in every 1,000 children who has measles develops an infection of the brain that can cause convulsions (seizures, fits, spasms, twitching, jerking, staring spells), hearing loss, and mental retardation. In the United States, 1 in every 500 to 10,000 children who gets measles will die from it. Babies and adults who get measles are often much sicker and are more likely to suffer longer or die than elementary-school-age children and teenagers with measles.

Mumps causes fever, headache, and swollen, painful glands under the jaw. Mumps is sometimes a very serious disease. Mumps lasts for several days and is easily passed from person to person. In recent years, between 4,500 to 13,000 cases of mumps were reported in the United States each year. Mumps causes meningitis (inflammation of the coverings of the brain and spinal cord) in about 10 percent of the people who get it. Swelling or inflammation of the brain occurs in about 1 in every 200 cases. Before there was a mumps vaccine, many children with mumps developed hearing loss. Twenty-five percent of teenage and adult males who get mumps have a painful swelling of their testicles for several days. This usually does not make the person unable to father children. Teenagers and adults, especially males, who get the mumps are often sicker and suffer longer than children do.

Rubella is also called German measles. In recent years, only a few hundred cases of rubella were reported each year. Rubella is usually a mild disease that lasts a short time. Rubella is most dangerous to unborn babies. Up to half of women who contract rubella when they are pregnant lose their babies or will have babies born blind, deaf, with heart disease, or with learning problems.

People with rubella usually have mild fever, swollen glands in the neck, and a rash that lasts up to 3 days. Seventy percent of the women who get rubella experience arthritis (soreness and swelling in their joints). The arthritis usually lasts for 1 to 2 weeks. In rare cases, the arthritis can last for months or years, or can come and go. About 10 percent of the women in the United States are not protected against rubella.

One MMR-vaccine shot protects 90 to 98 percent of the people immunized from getting the diseases. Children usually get the first MMR shot when they are 12 months old (or earlier if there is an outbreak). Children should get a second MMR shot when they start school for the first time. Teenagers and adults who do not know if they are protected from these diseases should ask their doctor or primary-care provider about getting an MMR shot.

Most people do not have a negative reaction to the MMR vaccine. Some people have minor reactions, such as a sore or red arm for 1 or 2 days. Rarely does a person have a serious negative reaction to the vaccine. If negative reactions occur, they almost always happen after the person receives the first MMR shot. If you or your child receives the MMR shot, any of the reactions listed below could occur. If you or your child receive only the measles, the mumps, or the rubella vaccine, you should look for the reactions indicated for each as follows:

- **Measles:**
    - A rash 1 to 2 weeks after receiving the vaccine. About 5 percent of children get a rash.
    - A fever of 103^{o}F or higher after receiving the first vaccine, even though your child may not appear to be sick. Five to 15 percent of the children who receive the vaccine get a fever. The fever can happen 1 to 2 weeks after the vaccine is given and usually lasts 1 or 2 days.

- **Mumps:**
    - A little swelling of the glands in the cheeks and under the jaw that lasts for a few days. This can happen from 1 to 2 weeks after getting the mumps or the MMR vaccine. This reaction rarely happens.
- **Rubella:**
    - Swelling of the lymph glands in the neck or a rash that lasts 1 or 2 days. This could happen 1 to 2 weeks after getting the rubella vaccine and occurs in about one of every seven children.
    - Mild pain or stiffness in the joints that may last up to 3 days. This could happen from 1 to 3 weeks after getting the vaccine. About 1 percent of the children and 25 percent of the adults suffer this reaction. Women have this problem more often than men. Only rarely does pain or stiffness last for months or years. This pain and stiffness can come and go.
    - Arthritis. This reaction happens to fewer than 1 percent of the children who get the rubella or MMR vaccine. Ten percent of the adults also have this problem, which usually lasts a few days to a week. Only rarely does the swelling last longer or appear and disappear. Damage to the joints is very rare.
    - Pain, numbness, or a "pins-and-needles" feeling in the hands and feet that lasts for a short time. This rarely happens.
- **More serious complications:**
    - Brief convulsion. This rarely occurs; but when it does, it happens 1 to 2 weeks after the vaccine is given and usually is caused by fever. The reaction is a brief convulsion occurring in children 6 months through 6 years old after they get the vaccine. Very rarely, hearing loss is reported. Also very rarely, a person has inflammation of the brain after receiving the vaccine. This usually clears up completely. These brain problems have been reported to happen about once in every million MMR shots given.
    - Other serious problems. There is a rare chance that the vaccine may cause other serious problems, even death. These reactions usually happen after taking other medicines or after receiving other vaccines.

Some people may need to delay getting the MMR vaccine or should not get the vaccine at all. These reasons also apply to persons receiving only the measles, the mumps, or the rubella vaccine. Tell the doctor or nurse giving the vaccine if your child--

- Has ever had an allergic reaction from eating eggs and the reaction was serious enough to require medical attention. This problem does not apply if your child is receiving only the rubella vaccine.
- Has had an allergic reaction to an antibiotic called neomycin and the reaction was serious enough to require medical attention.
- Has a disease that makes it hard for the body to fight infection. Examples of these diseases are acquired immune deficiency syndrome (AIDS), cancer, leukemia, and lymphoma.
- Is taking drugs or receiving special cancer treatment, such as radiation, that make it difficult for the body to fight infection. Examples of these drugs are prednisone and other steroids.
- Has received gamma globulin during the past 3 months.

Children seldom have a convulsion because of fever after receiving a measles vaccine. However, the risk is up to five times greater if a child has had a convulsion before. Chances are also greater if a child's sibling or parent has had a convulsion. Children who have had a convulsion or who have a family member who has had a convulsion should still get the MMR immunization. Parents should tell the doctor or nurse who is giving the shot about any history of convulsions. Parents should talk with doctors or nurses about medicines or other measures to reduce fever or soreness from the vaccine. If a woman of childbearing age needs an MMR, a pregnancy test should be done before she is given the vaccine.

Inactivated Polio Vaccine (IPV). As recently as the 1950s, polio was a common disease in the United States. In 1952, more than 20,000 people were paralyzed by polio. Because children and adults now receive the polio vaccine, there are only a few cases of polio reported each year in the United States. There are many thousands of cases of polio each year in other countries. Parents should have children vaccinated to protect them from those with polio from other countries.

Mild cases of polio may involve fever, sore throat, stomachache, or headaches. Mild cases usually last only a few days. Serious cases involve severe muscle pain. This pain can prevent the person from moving their arms or legs and can make it difficult for the person to breathe without the help of a machine.

There are no drugs or special treatments that cure polio. Most people who are paralyzed by polio will have some weakness in an arm or leg for the rest of their lives. Many of these people are seriously disabled.

The poliovirus in the IPV is dead and is given as a shot. The current recommendation is to give all the doses as IPV. Ninety percent of the people who get three or more doses of IPV are protected from polio. The recommended protection from polio is four doses of IPV. Most babies should get two doses of IPV by the time they are 4 months old. They should get a third dose of IPV when they are between 12 and 18 months old. They should get the fourth dose when they are between 4 and 6 years old. If there is a case of polio in your neighborhood or where your child goes to school or day care, your child may need another dose of the vaccine. Your doctor may also suggest that your child get another dose before your child visits a country where polio is common.

The IPV causes problems in very few people. The IPV--

- Can cause a little soreness and redness where the shot was given. There is a very rare chance that other serious problems, even death, may occur after receiving the vaccine. These reactions usually happen after taking other medicine or after receiving another vaccine.

- Should not be given to persons who have had an allergic reaction to the antibiotics neomycin or streptomycin and if the reaction was so serious that it required medical attention.

Hepatitis B Vaccine (HBV). Hepatitis B causes major health problems in the United States. The number of hepatitis B cases reported increased by 37 percent from 1979 to 1989. About 200,000 to 300,000 new infections occurred annually from 1989 to 1991. The estimated 1 million to 1.25 million people in the United States with chronic hepatitis B infection are potentially infectious to others.

Preventing hepatitis B transmission during early childhood is important. Children under 5 years old who become infected have a high likelihood of chronic hepatitis B infection and chronic liver disease.

In the United States, children become infected with hepatitis B through a variety of ways. Ten to 85 percent of the children born to mothers with hepatitis B contract the disease. These children have a 90-percent chance of chronic infection. As many as 25 percent of those children will die of chronic liver disease as an adult. Even the children born to mothers with hepatitis B who do not contract the disease prenatally are at a higher risk of acquiring chronic hepatitis B by person-to-person transmission during their first 5 years of life. More than 90 percent of these infections in children can be prevented if mothers with hepatitis B are identified; this helps ensure that the infants can receive the HBV and hepatitis B immune globulin (HBIG) soon after birth. Unvaccinated children under 5 years old who live in areas where the hepatitis B virus is widespread frequently acquire the disease.

In the United States, most people with hepatitis B acquire the infection as adolescents or adults. Most hepatitis B is spread by intravenous drug use or by sex. However, cases of hepatitis B transmission through close contact, such as at day-care centers, have been documented.

The vaccination schedule most often used for HBV recipients is three shots. The second and third shots should be given 1 and 6 months, respectively, after the first. This series of vaccinations produces a protective antibody response in more than 95 percent of children and adolescents who receive the shots. Infants born to mothers with hepatitis B should receive the appropriate doses of HBV and HBIG within 12 hours after birth. The vaccine is currently given at birth, when a child is 1 month old, and again when the child is 6 months old. Children and adolescents who have not been vaccinated against hepatitis B may begin the series any time. DODDS schools require that children begin the series before entry into school. Mild negative reactions from the vaccination include pain where the shot was given and a temperature higher than 100^{o}F.

Hemophilus B Conjuate Vaccine (Hib). Hemophilus influenza is a bacteria that causes severe meningitis in children. It can also cause pneumonia, arthritis, and epiglottitis (a severe throat infection). These illnesses can be very serious and are prevented with the vaccine. Children should receive Hib when they are 2 months old and 6 months old. A booster vaccine should be given when a child is 12 to 15 months old. Hib has no serious side effects, but can cause a low fever.

Chickenpox (Varivax). Most children who contract chickenpox recover with no more than a few scars. Some cases of pneumonia and severe bacterial infections (including Toxic Shock Syndrome and meningitis) occur infrequently. The Varicella (chickenpox) vaccine is now in use in the United States and U.S. military health-care facilities in the European region. This vaccine has been in use in the Far East for more than 20 years. It is now approved for use in the United States. The vaccine is about 80 percent effective in preventing cases of chickenpox and is 98 percent effective in preventing the rare but serious or life-threatening complications of chickenpox.

The vaccine can be given as a single dose to children as young as 12 month old. Adolescents who have not had chickenpox or the vaccine before they are 13 years old should have two doses at least 1 month apart. The vaccine may cause a mild case of chickenpox 10 to 21 days after the vaccination. Less than 1 percent of these cases are actually contagious and able to transmit a mild case of chickenpox. DODDS schools require a history of chickenpox or the chickenpox vaccine for school enrollment.

Immunization Records. Guard your child's immunization records carefully. Proof of immunizations is required to enter public school. Always have immunizations recorded in your child's medical record as well as in the yellow international immunization record. Keep the yellow record in a safe place at home.

POISON CONTROL

Approximately 6 million people swallow toxic substances each year in the United States. Although most ingestions result in minimal complications, many children die each year from swallowing poison. Prevention is the best defense against swallowing poison. Children are curious, capable explorers. Ensure that poisonous substances and medications are not left where children can get to them. Any non-food substance can be poisonous.

Prevention. Keep hazardous substances out of children's reach. Use child-resistant containers. Keep the containers in locked areas. Know what your child is doing. Many poison-swallowing incidents occur when children are left unsupervised for long periods. Follow these guidelines:

- Get down on your hands and knees to observe your child's perspective. Keep poisons in high cabinets or behind safety locks.
- Read labels and use medications and hazardous substances correctly.
- Never store poisonous substances in food or drink containers. Keep poisonous substances in the original containers.
- Have adequate ventilation when using cleaning materials.
- Give medication only to the person for whom the medication was prescribed.
- Never treat medication as candy.
- Avoid taking medication in front of your child. Children love to imitate their parents.
- When medication is no longer needed or is outdated, discard it safely. The safest way to discard medicine is by flushing it down a toilet.
- Teach children to avoid eating or putting unknown substances into their mouths. These substances include plants, berries, and leaves.
- Know if there are poisonous plants in your home, yard, or where your children play. Remove poisonous plants if your child is not constantly supervised. Below is a partial list of common poisonous plants:
    - Field plants: death camas, European bittersweet, horse nettle, jimsonweed, nightshade, poison hemlock, pokeweed.
    - Flower-garden plants: aconite, crocus, delphinium, Dutchman's breeches, foxglove, iris, larkspur, lily, monkshood, nicotiana.
    - Forest plants: baneberry, jade-in-the-pulpit, may apple, skunk cabbage, water hemlock.
    - Holiday plants: holly, Jerusalem cherry, mistletoe, poinsettia.

- Houseplants: caladium, castor bean, daffodils, dieffenbachia, elephant's ears, hyacinth, philodendrons, rosary pea.

- Tree and shrubs: apple (the leaves), black cherry (the leaves), black locust, buckeye, chinaberry tree, chokecherry, elderberry, jatrophia, oak, horse chestnut, yellow-oleander.

- Vegetable-garden plants: potatoes (the leaves), rhubarb (the leaves).

What To Do. If you think your child has swallowed a poisonous substance, check your child. Conduct immediate, basic life support if necessary. If your child will not wake up, make sure that he or she is breathing. If your child is awake, ask these questions:

- What did you eat (drink)?
- How much did you eat (drink)?
- How long ago did you eat (drink) the poisonous substance?
- How do you feel?

Immediately call the local emergency room. Do not induce vomiting until instructed to do so by a poison-control center or an emergency-room physician. If the physician tells you to cause vomiting, use Ipecac syrup or your finger to do so.

Do not make your child vomit if he or she--

- Is unconscious or drowsy.
- Is convulsing or having tremors or uncontrolled body movements.
- Swallowed a strong corrosive or drain cleaner, a toilet-bowl cleaner, a strong acid, furniture polish, kerosene, gasoline, or other petroleum product.

Take the container that the poisonous substance was in with you to the hospital, even if the container is empty. If the child is not medically stable, call an ambulance. Common substances that are readily available are most often ingested by children. These substances include tobacco, alcoholic beverages, cleaning substances, office supplies (such as correction fluid), aspirin, and Tylenol. All of these substances and many others can be extremely dangerous to children. Children often swallow poisonous substances outside of their home when visiting a relative's or friend's home that is not childproofed.

CAR-SAFETY SEATS

According to the National Safety Council, more children die as passengers in automobile accidents than by any other cause of death. Many children are seriously injured, sometimes permanently. Most of these deaths and injuries could have been avoided by properly using a car-safety seat. Children who are younger than 4 years old or who weigh less than 50 pounds must ride in a car-safety seat. Older or heavier children must use adult restraints. Youth seats are available for children who weigh 40 to 65 pounds.

Children are not safe in an adult's arms in an automobile. A 10-pound baby riding in a car traveling at 30 miles per hour has an impact force of 300 pounds if involved in an accident. No parent can properly hold a child during an accident.

Parents must ensure that car-safety seats are properly installed and that the restraining belts are secured firmly around the child. Research shows that a properly secured child behaves better in the car. In turn, parents who put their child in a car-safety seat often avoid accidents, because this prevents their being distracted by the child's moving around in the car.

The correct position for a car-safety seat for an infant is in the middle of the back seat, facing backward. A rear-facing infant-only seat may be used for infants up to 1 year old. Infants using these car-safety seats may weigh up to 20 pounds. The car-safety seat should always be secured to the car seat according to the car-seat safety instructions. Car-safety seats should never be installed in a seat that is equipped with an airbag. The deployment of the airbag may cause fatal injuries to a young child. Children under 12 years old or less than 60 inches tall should not sit in seats protected by airbags. The rear seat is the safest place for a car-safety seat. Check the laws of the country where you are stationed for additional requirements for car-safety seats or seating position in vehicles.

TIPS FOR TAKING CARE OF YOUR CHILD WHILE YOU ARE ON LEAVE

If you have arranged to leave your child with a sitter while you are on vacation or while you are out of town, prepare a power of attorney for the sitter. You can get a power of attorney at your local legal assistance office. The power of attorney authorizes the sitter to have your child treated for acute or emergency medical care. Ensure the sitter has an address or telephone number where you can be reached. Call the sitter from time to time.

If you plan to take your child with you on a trip, have adequate supplies of diapers, food, ready-to-feed formula or a safe water source for preparing formula, and clothes. Above all, ensure your child travels in an approved car-safety seat at all times.

SECTION V
BEHAVIOR MANAGEMENT

INTRODUCTION

Parents want children to be well-behaved and obedient. Unfortunately, children are not born knowing the rules of behavior in our society. Children must be taught how to behave by their parents, teachers, other adults, and peers. This section will give you some practical suggestions for teaching your children what is expected of their behavior.

GOALS AND RESPONSIBILITIES OF PARENTS

The ultimate goal of raising children is to develop a responsible and productive future member of our society. It has often been said that parents are teachers. Parents are the first people that children know. Parents have the most influence on the future of their children.

Children imitate the behavior of their parents. If a parent uses foul language, fights, lies, cheats, or has difficulty getting along with people, their child will probably develop the same problems. Therefore, the first and most important responsibility that parents have is to set a good example for their children. Good examples will go a long way to prevent behavioral problems. The second job parents have is to provide a warm and loving home. Parents should not be afraid to tell children that they are loved and wanted. Children cannot be spoiled by love. Studies have shown that the most successful people in life came from loving homes.

A popular car sticker says “Have you hugged your child today?” You should hug your child many times a day and tell the child that you love him or her. Strive to do the following:

- Teach your children to respect themselves and others.
- Shape your children’s will without breaking their spirit.
- Build your children’s self-esteem.
- Avoid overprotecting your children or making them overly dependent on you.
- Tend to your own personal and marital needs.

There will be many times you will not like how your child behaves. Children about 1 year old are likely to scream, shake their crib, or do anything else they can to get attention. These children often are not trying to be naughty; they just do not know another way to tell people how they feel. Your child may get very upset and hit or bite you. Later, he or she may say things like “bad mom” or “I hate you.” You will probably hear your child use expressions of anger that you have used. Let your child know that it is okay to feel angry and to say such things. Remember, there will be times when your child will not be able to do what he or she wants because you are busy or because it is not safe. Your child will be upset. Give your child words to express emotions; letting your child use those words is better than having the child scream, cry, or throw things. In fact, it is better for both of you to get rid of feelings of anger than to keep the feelings pent up. Give your child words to show anger and sadness, as well as happiness. When you show your anger, do it in a way that you would consider acceptable for the child. If you are a door-slammer, wall-kicker, or nose-puncher, your child is likely to become one too.

Children often test their parents to see how parents will react. Your child might think “Did mommy really mean it when she said not to take the pans out of the cupboard?” If you always respond in the same way when you are tested, your child will learn what he or she can and cannot do.

Children interact with and react to their parents from the day they are born. Parents must immediately begin to guide their children. Once certain patterns become usual or normal, they are difficult to change. For example, changing a baby's feeding schedule from every 2 hours to every 4 hours is difficult. Teaching a child not to touch certain breakable objects is difficult when the child has been allowed to touch everything in the house.

Both parents must agree on the limits set for their children. Children quickly learn which parent says yes more often. You will be better parents and your children will respect you more if you support each other. Discuss the limits to be set when the children are not around and agree on a plan of action that you both will carry out.

Children learn quickly when they know their limits. If you do not want your daughter to throw food on the floor, do not laugh when she does this and tell her she is cute on some occasions and tell her not to throw food on other occasions. Children need to know that if something is wrong, it is always wrong at your house, no matter how tired you are, how much you would like to avoid dealing with the problem, or which child disobeyed. If a child continually gets his or her way at a young age, you will have a more difficult time setting limits as the child gets older.

DISCIPLINE

The dictionary defines discipline as "training that corrects, molds, or perfects." Discipline is not always punishment. Punishment is a penalty for a fault. There are many ways to discipline a child (for example, taking away privileges such as watching television, making the child sit in a corner or in a bedroom). Discipline does not have to be negative. Treat your child with respect. Your child will respect you when you--

- Let the child know that what he or she says and does is important to you.
- Do not embarrass your child in front of his or her friends.
- Do not punish your child in front of others.

Discipline your child when he or she tests limits or when he or she knowingly disobeys the limits. Do not discipline your child for the following reasons:

- Childishness, forgetfulness, or immaturity.
- Problems beyond the child's control (such as bedwetting).
- Childish curiosity. Toddlers are explorative and want to touch everything. By moving most of the breakable objects out of the child's reach, he or she will not be tempted. Distract your child with a toy.

When your child does something requiring discipline, try to talk with him or her first. Never hit your child in anger. Community and Army regulations limit spanking to an open hand on the buttocks only. No other instrument may be used to spank.

Parents should follow these guidelines:

- Discipline your child before you get angry. Your home will be happier if you punish your child's disobedience before you lose your temper.
- Balance discipline with love. A child is a great responsibility, but also a great delight. Discipline is something you do for your child, not to your child. Children have an uncanny ability to live up to your expectations, whether they are high or low. If you repeatedly tell your child he or she is stupid, dumb, or clumsy, he or she will believe what you say and will act accordingly. If you praise your child and tell him or her how smart, polite, or considerate he or she is, your child will live up to those expectations.
- Be honest and consistent with your child. Do not allow your child to behave badly. Do not threaten your child. Teach your child that you mean what you say.
- If your current methods of discipline are not working or if you feel like you are out of control, change something to make your discipline work. Army community services and many chapels offer parenting classes to help you learn, among other things, disciplinary techniques.

- Do not compare your children to one another or compare your child to someone else's child (for example, "Why can't you be more like Beth? She never gets Ds on her report card. She always picks up her toys. She is good at soccer. She never gets into trouble at school."). Comparisons can cause many problems between siblings, can make developing relationships between your child and other children difficult, and can hurt a child's self-esteem. Instead, tell your child, "I am unhappy with your behavior today." Say, "You did well today. I'm proud of you," instead of "You did better than your brother did." Children need to know that you love them for who they are and not for how they compare to their siblings or other children.

- Teach by example. Children learn by imitating their parents. Setting a good example is therefore important. Your family members must treat one another with respect. That means parents should treat their children with respect, too. Parents should also say "thank you," "excuse me," and "I'm sorry." If parents treat each other with respect and love and teach the children to respect their parents, a solid foundation is formed. If your family members treat one another with love and consideration, your children will learn the same principles. Love is shown in many ways, every day. Love is recognizing another person's accomplishments. Letting your child know that you notice that he or she can dress himself or herself better or that he or she can eat without making a mess is an example of giving love. Love can be merely touching someone, giving a hug or kiss, or complimenting personal appearance. Parents should plant the seed of love in their children when the children are infants and nourish that love throughout childhood.

- Be positive. Everyone prefers praise over criticism. As parents, understand the need to balance your demands with praise, understanding, and compassion.

- Concentrate on the behavior, not the child. When disciplining a child, do not say, "You are a worthless, good-for-nothing child." Instead, point out what rule was broken. Express your displeasure without insulting your child.

BUILDING SELF-ESTEEM

Be sensitive to your child. Be careful what you say about your child when he or she can hear you. The child is more alert to your statements about him or her than about any other subject. Parents often take their children to the doctor and discuss everything that the child does wrong in the child's presence ("he or she gets in trouble at school," "he or she is a slow learner," "he or she cannot sit still"). Imagine how you would feel if your spouse or your boss did that to you.

Teach your children a "no-knock" policy. Teach them that self-criticism is a bad habit that does not accomplish anything. There is a difference between accepting blame when justified and chattering about one's own inferiority.

Help your child understand that some children have more problems than others. Perhaps your child is clumsy or has a severe learning problem. You can help your child deal with problems by helping your child find his or her strengths. Knowing these strengths will help your child balance his or her weaknesses. Expose your child to art, music, and sports, or teach your child to build things, to sew, to practice photography, or to cook. Even though your child may not excel at some things, he or she will have some skills that will give satisfaction and build self-esteem.

Help your children feel good about themselves. If you want a predictable indicator of the kind of adult your child will become, do not ask, "What do I think of my child?" or "What do my child's friends and teachers think of him or her?" Instead, ask, "What does my child think of himself or herself? Does my child have confidence that he or she can complete a task? Does my child feel good about how he or she looks? Does my child feel intelligent? Does my child think of himself or herself as worthy?" As a parent, be concerned with these questions. If you feel that your child lacks self-esteem or feels unattractive, take steps to make the child's self-image more positive.

Self-esteem is one of the most important things a child needs to become a productive, happy, well-adjusted adult. If the child thinks he or she is not worth much, he or she is likely to act that way. Remember that your child's self-image is a direct result of the reinforcements you give him or her daily.

Parents must understand the difference between a child who has high self-esteem and a child who disguises low self-esteem with bragging and conceited behavior. If your child always feels a need to be in competition with or superior to others, your child probably has low self-esteem. You can help your children raise their opinions of themselves by using common sense and by looking honestly at your own attitudes and behavior toward yourself and your child.

Setting an Example. Imagine your doctor lecturing you on the importance of giving up smoking as he or she lights up a cigarette. Visualize yourself at an exercise class where an overweight, out-of-shape instructor talks authoritatively about the virtues of being physically fit. You would think that the doctor and the instructor are phonies. Similarly, if you constantly put yourself down, you show your child that you do not think very highly of yourself. That puts you in a poor position to help your child raise his or her self-esteem. You must show your child that you are a person who has self-respect if you want that self-respect to rub off.

How do you show your child that you have self-respect? You can start by not putting yourself down. Avoid saying, "I have never been very good at this" or "I am too old to do this." Instead, let your child hear positive things from you. Say, "I will give it a try," "We will figure this thing out together," or "You are never too old to learn something new." Saying these things may seem a trite way to begin boosting your child's self-confidence, but remember that little day-to-day interactions ultimately build a child's psychological self-portrait. Simply saying these things is not enough. Show your child that you are a person who treats himself or herself with respect and who will not tolerate anything less from anyone else. If you hear your child use bad language, stop him or her by saying, "I have too much respect for myself to listen to such talk. You will not talk to me or to anyone else like that ever again." Use no-nonsense, straightforward statements declaring why you will not tolerate such behavior.

Strategies for Raising Your Child's Self-Esteem. In addition to setting a positive example, you must reverse your child's low self-esteem. You can do this by following these procedures:

- Encourage your child to try new things. Remind your child that failing a task does not mean failing as a person. Encourage your child to try out for the basketball team or to swim two laps underwater, then praise the effort, whatever the outcome. Stress safety, but know that a safe child who avoids risks will have lowered expectations of his or her abilities and, consequently, will have low self-esteem.

- Discourage your child from putting himself or herself down. If your child says, "I can't do anything," "I'm ugly," or "I'm clumsy," counteract these negative comments with positive reinforcement. Say, "You can do anything you put your mind to." If your child hears this often enough, he or she will incorporate these positive attitudes into his or her own thoughts and speech.

- Do not emphasize material rewards. Equating self-worth with only external measures of success (such as high grades, merit badges, or trophies) is a sure way to lower a child's self-esteem. Self-esteem comes from the self, not from acquisitions and approval. Ask your child, "Do you think you are improving your spelling?" rather than, "Did you win the spelling-bee competition?" The child who understands that he or she can have a feeling of accomplishment, even without an external reward, is headed for his or her own measure of success.

- Criticize a child's behavior rather than the child's value as a human being. Saying "You are a bad boy or girl!" attacks your child's worth and lowers his or her opinion of himself or herself. Saying "You behaved badly" concentrates on behavior that can be adjusted.

- Be on guard for the "I'm bored" routine. A child who is genuinely bored is showing contempt for himself or herself and for his or her surroundings. You will lower a child's self-esteem by taking over and organizing his or her life. When your child is bored, point out that there are countless things to do at any moment. A child can read a book, go for a walk, invent a new ice cream flavor, or just think. A bored child does not enjoy being alone because he or she does not enjoy being alone with himself or herself.

- Teach your child the importance of independence. As infants, children depend on you; but as they grow, you must encourage them to try things on their own. You can help them by not being an overprotective parent. Independence breeds self-esteem; dependence inhibits it.

- Urge your child to be nonjudgmental. People who are critical and prejudiced have a need to make others look bad so that they can feel positive about themselves. When you genuinely like yourself, you are not threatened by anyone who is different from you. Correct your children, for example, when they refer to old people in a derogatory way. Say, "Do you need to put down older people to make yourself feel more important?" This simple question will make your child think twice before passing judgments.

- Help your child to look good and to feel well. Appearance is important to children, so help your child develop a self-improvement program. Run a mile a day with your child, refuse to buy junk food and sugar products if your child has a weight or complexion problem, and urge your child to make good health a life-long commitment. When your child does something constructive, his or her self-esteem will increase.

HOW TO IMPOSE LIMITS ON CHILDREN

There are many ways to teach children how to live within limits. The most important fact to remember is that children at different ages learn limits differently. A child 18 months old does not understand that you cannot run out into a street. You can easily teach a child 5 or 6 years old, however, not to run out into a street. Make the lesson appropriate to the child's age.

To succeed in setting limits, you must first define the limits. Both parents must agree on what is permitted. Whether a family is strict or liberal does not make a difference. Consistency in setting limits is what matters. Often, parents must reach a compromise concerning limits. Disagreements over limits can lead to family arguments and confused children.

When limits have been defined, explain them to your child. Parents often punish a child without fully communicating exactly what a child did wrong, which diminishes the effect of the discipline. The best way to ensure that a child understands that what he or she did was wrong is for the child to repeat, in his or her own words, why he or she is being punished.

What should parents expect from their children at different ages? How old should the child be before he or she can be disciplined? Most experts agree that children younger than 1 year should not be disciplined. Children at this age are not capable of understanding the concept of controlling behavior. Attempting to discipline a child who is too young to understand the principle of discipline creates frustration for the parents and mental anguish for the child.

When a child is 2 years old, emphasize safety. The child needs to be taught what is safe and what is not. This is a time for exploration, emerging independence, and short memory. A 2-year-old child will explore and will get into trouble. A child will roam farther from the parent's side. A child will want to test the parents and to ensure that what was "No!" last time is still "No!" this time. Children 2 years old have trouble remembering what was "No!" until it has been repeated many times. The key to parenting children 2 years old is patience and consistency. Removing tempting objects is often the best way to prevent potential trouble. Do not get frustrated with the need to repeat things for your child. Repeating is key to modifying behavior.

After their second birthday, most children begin learning the rules of our society. One of the best and most effective ways to teach your child discipline is to place a chair in the middle of a room with no television to watch or radio to listen to. Put your child in that chair when he or she does something that you feel is not appropriate. Your child should sit in the chair for 1 minute for each year of age, up to 5 minutes. When the time is up, ask your child what he or she did wrong. Next, ask your child if he or she wants to do it again. Say, "If you do it again, you will sit in the chair again." Saying this reinforces the concept that the punishment will be the same if your child repeats the undesirable behavior. Most children will quickly understand the concept of the "time-out chair" and not repeat the inappropriate behavior. This approach to discipline is appropriate until the child is 10 or 11 years old.

There is another way to set limits. If parents reward good behavior, children will spend more time behaving well and not concentrate on behaving badly. Everyone responds to rewards, regardless of age. If children are told that they are behaving well, they will feel positive about themselves. Praise only takes a minute, yet it goes a long way toward improving behavior and self-esteem. When you see your child reading quietly, playing with a friend without fighting, sitting in a car without getting on the driver's nerves, or simply acting pleasant for the past 5 minutes, tell the child that you like his or her behavior. Rewarding good behavior is the best teaching method known.

Do not tell a young child to "be good" or to "behave." These are abstract concepts that children do not understand until they are 9 or 10 years old. Be specific about the behavior you expect of your child. Say, "Do not fight with your brother" or "Sit still without wiggling." The more specific you are, the better your child will behave.

LOVE

Parents who love their children sometimes have difficulty communicating their love to their children. An age-old belief is that showing affection for your children will spoil them. That is not true. Love does not spoil children; it makes them better people. Children who are raised in a loving home show love as adults.

Discipline and love are not exclusive. Children often mistake discipline for punishment. Parents must make it clear to their children that although they may not like what their children do, the children are still loved.

One way to show love is to be interested in your child's activities. Ask your child about school or about his or her playtime. Get involved with your child's church, scouts, or sport activities. If your child feels that his or her activities are important to you, a better parent-child relationship will be built.

ATTENTION PROBLEMS

Some children have problems paying attention. A short attention span is normal for children 2 through 4 years old, and occasionally for children 5 years old. As a child gets older, his or her ability to pay attention and to concentrate should improve.

There can be many reasons why a child lacks the ability to pay attention. A child may have trouble understanding schoolwork or may be bored. A child may also be worried about family problems. A child's physician and teacher, working as a team, can help determine why the child is having trouble paying attention. Solutions to attention problems can be as varied as the causes. These solutions include behavior modification in school and at home, or medication. A child's physician and teacher can help you and your child find the best solution to the problem. If you feel your child has an attention problem, discuss it with your child's teacher and request a school evaluation.

The attention span of some children improves more slowly than that of others. The inability to pay attention appropriate to the child's age could be due to something called attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD). ADHD is a problem that can occur either with or without hyperactivity. The major features of ADHD are a short attention span, impulsive actions, restlessness, easy distractibility, possible hyperactivity, poor coordination, and frequent mood changes.

If a child repeatedly does at least eight of the following things for at least 6 months before the child is 7 years old, the child may have ADHD:

- Often fidgets with hands or feet or squirms in the seat. In adolescents, this problem may be limited to restlessness.
- Has difficulty remaining seated when required to do so.
- Is easily distracted.
- Has difficulty waiting his or her turn in games or group situations.
- Often blurts out answers to questions before the questions have been completely asked.
- Has difficulty following instructions from others (not because the child does not want to follow the instructions or does not understand the instructions). For example, the child fails to finish his or her chores.
- Has difficulty paying attention to tasks or to play activities.
- Often shifts from one uncompleted activity to another.
- Has difficulty playing quietly.
- Often talks excessively.
- Often interrupts or intrudes on others, such as interfering with other children's games.
- Often does not seem to listen to what is being said to him or her.
- Often loses things (such as pencils, books, and assignments) necessary to complete tasks or activities at school or at home.
- Often engages in physically dangerous activities without considering possible consequences (this does not include "thrill-seeking"). An example is when a child runs into a street without looking.

Approximately 3 to 5 percent of all children show some characteristics of ADHD. Children who have ADHD have difficulty with the part of the brain that controls concentration and organization. They cannot control, organize, and coordinate their actions as other children their age can. While watching television, most people do not pay attention to the fan in the next room, the kids playing outside, the car on the street, or the color of the toys on the floor. A child with ADHD cannot filter these out.

The degree of restlessness varies from child to child. As a child grows older, the problem seems to improve. There is no specific test for ADHD. The diagnosis is based on the signs described above.

The following problems may indicate motor deficiencies in your child:

- Awkwardness in running and climbing.
- Inability to hop, skip, and jump.
- Inability to catch, throw, or hit a ball.

The following problems may indicate slight motor deficiencies in your child:

- Inability to lace shoes, tie a bow, button a shirt, or open and close a zipper.
- Delayed development or poor attainment of the ability to reach, grasp, and release.
- Inability to hold a pencil properly, resulting in poor writing skills.
- Generally diminished dexterity.

Children with ADHD may also have other learning problems, such as perceptions of space, form, movement, and time. A child may reverse his or her letters and numbers, confuse right and left, or not understand the concepts of yesterday, today, and tomorrow.

Approximately 70 percent of the children who have ADHD will show signs of improvement by the time they are 16. Thirty percent will retain the disorder, and 9 percent of that 30 percent will continue having difficulties.

Treatment of ADHD. Seventy to 80 percent of the children who have ADHD can benefit from medication. Medicines most commonly used are stimulants, such as Dexedrine and Ritalin. These medications stimulate the part of the brain that controls attention, allowing the brain to filter out distractions more effectively. Some side effects of stimulants are decreased appetite, decreased sleep, and mood swings. Some doctors prescribe this medicine to be taken every day; others prescribe the medicine to be taken only on school days.

Medication is only one part of treating ADHD. Further evaluations done by school personnel and a child's physician can help identify a child's strengths and weaknesses in learning. This information can contribute to an appropriate plan of management. Environmental controls are very important to manage an ADHD child. An ADHD child needs to be in a quiet, well-structured, controlled environment. Loud music, brightly colored drapes, bedspreads, or pictures are very stimulating to an ADHD child. Loud children running through the house are another aggravating factor. In the classroom, an ADHD child benefits from a firm teacher and strict discipline.

Parents and teachers who are loud, bubbly, happy, emotional, and active stimulate the ADHD child. Peers and siblings can have the same stimulating effect. A classroom that is very busy with pet animals, paisley-colored cardboard carpentry, mobiles, and colorful pictures on the walls is very stimulating to the ADHD child. An ADHD child benefits from a quiet place to do homework without the distractions of radio, television, or loud children.

The effect of diet on hyperactive children has been a controversial topic for 10 to 15 years. Researchers have not been able to prove that diet and stimulation have any relation to ADHD. However, some overactive children respond to the elimination of sugar, artificial colors, flavors, preservatives, or caffeine in their diet. If you are interested in trying this elimination diet on your child, restrict serving the foods mentioned above for 2 weeks. During those 2 weeks, observe your child's behavior and activity level.

CHILD ABUSE

Child abuse is an action by an adult that injures a child. Abuse can be physical or emotional. Sometimes the actions are deliberate. Other times they are not. Often, people injure children because they do not know how to respond to children's needs and desires. One percent of all children in the United States suffer some form of child abuse. Approximately 380 cases of child abuse are reported per million people each year. Approximately 3,000 children die of child abuse each year in the United States. Child abuse is the second leading cause of death in children over 1 year old, second only to accidents.

Various forms of child abuse, with a short description of each, are listed below:

- Physical abuse. This includes beating, shaking, or burning a child, and failing to provide the necessities of life such as food, shelter, and clothing.

- Nutritional neglect. This is failing to provide balanced, nutritional meals. An example of nutritional neglect is offering a child only candy and soda when that is all the child will accept. As a result, the child is not nourished, does not gain weight, and is later admitted to a hospital for serious undernourishment.

- Drug abuse. This occurs when parents knowingly give their child dangerous drugs or appropriate drugs in excessive amounts with the intent of causing harm.

- Medical-care neglect. This occurs when parents purposely avoid seeking medical attention for their child's obvious health problems.

- Sexual abuse. This includes incest and other inappropriate sexual activities involving the child.

- Emotional abuse. This is the failure to provide warmth, understanding, and compassion under normal living experiences.

- Verbal abuse. This involves excessive yelling or screaming to belittle or degrade the child.

- Safety neglect. This occurs when parents do not take appropriate precautions to protect their child from physical harm. An example is allowing a toddler to play in an unenclosed yard without someone to protect the child from running into the street. Another example of safety neglect is not using a child-restraint system while the child is riding in an automobile.

Child abusers come from all ethnic, geographic, religious, educational, and social backgrounds. Ninety-five percent of child abusers are the child's parent or the parent's live-in friend. Ninety percent of abusing parents are neither insane nor criminal. Abusive parents are just average parents who often have been abused as children themselves. There are some common characteristics in people who abuse their children. The abusive parent usually--

- Has been abused as a child.

- Is provoked by some misbehavior.

- Has poor control of impulses.

- Uses aggression to teach the child to respect authority.

- Is frequently depressed or lonely.

Some children are more at risk of abuse than others. These children are usually demanding, possibly handicapped, hyperactive, strong-willed, or precocious. One third of abused children are younger than 6 months old, one third are 6 months old to 3 years old, and one third are more than 3 years old. Premature babies, adopted children, stepchildren, and handicapped (physically or mentally) children have a higher risk of being abused.

If you feel you need to learn new ways to deal with your child, call a chaplain, Army community services, your physician, or social-work-services personnel. If you know of a child who you think is being abused, report your suspicions to the military police, social-work services, or emergency-room personnel. You can save a life.

SCHOOL PERFORMANCE

Parents want their children to do well in school, but doing well does not come easily for many children. Often, school is not the rewarding experience for a child that it should be. You can help your children in school by establishing good communication with the teacher. Ensure that your child brings homework home and that your child takes the homework back to the teacher on time. Review your child's homework. If your child does not understand the work as well as he or she should, talk to your child's teacher. When the work is acceptable, praise your child. If the work is not acceptable, meet with your child's teacher early in the schoolyear. Later in the schoolyear, if your child's work has not improved, ask the teacher for another meeting. You can observe your child in the classroom if you volunteer to work for the teacher 1 day a week. Observing your child in the classroom is a good way to see where some of your child's school problems may come from.

Not all children can make straight As. However, all children can learn. School should be a rewarding experience for children. Parents and teachers should work together to help children enjoy learning.

GLOSSARY

ADD	attention deficit disorder
ADHD	attention deficit hyperactivity disorder
CPR	cardiopulmonary resuscitation
DtAP	diphtheria, tetanus, and acellular pertussis
DODDS	Department of Defense Dependents Schools
EDIS	early development intervention specialist
HBIG	hepatitis B immune globulin
HBV	hepatitis B vaccine
Hib	hemophilus B conjuate vaccine
HQ USAREUR/7A	Headquarters, United States Army, Europe, and Seventh Army
IPV	inactivated polio vaccine
MMR	measles, mumps, and rubella
NPESP	New Parent Education and Support Program
PD	personnel detachment
PKU	phenylketonuria
SIDS	sudden infant death syndrome
U.S.	United States
USAREUR	United States Army, Europe
WIC	Women, Infants, and Children