draft
July 30, 1995

FIRST LADY HILLARY RODHAM CLINTON
"CHILD HEALTH MESSAGE"
***PREVENTION* MAGAZINE**

As my husband always says, we cannot afford to waste a single person in America, particularly not a child. That is why we must all take responsibility for the health of our nation's children.

In recent years we have made considerable strides in improving health, education, and economic opportunities for American children. But even so, many of our young people face health and developmental challenges that undermine their ability to fulfill their potential and lead productive and happy lives.

Today, nearly 1/3 of all children under age three live in poverty. Too many are exposed to the problems of crime and violence in their own neighborhoods and schools. Millions lack the nutrition necessary to ensure proper growth and development. Compounding the problem, about ten million children do not have health insurance, making it difficult for them to take advantage of medical technology and care that can guard against illness and save lives.

Taking steps to protect our children's health is one of the soundest investments our nation can make. We have seen dramatic improvements in public health from some simple initiatives like adding fluoride to local water supplies, vaccinating children against diseases such as polio and reducing children's exposure to lead poisoning. In addition, Medicaid has provided millions

of disadvantaged children with important preventive health services.

Today, with immunization rates in America lagging behind many other developed countries, President Clinton has initiated a campaign to improve immunization services, lower costs, reach out to families and ensure that all young children receive the vaccinations they need.

But government will not succeed alone in promoting health among our children. Parents, physicians, teachers and other caregivers must work together to ensure that children get regular medical check-ups, proper nutrition, exercise, and sleep.

By focusing on preventive health care, this issue of *Prevention* magazine is a valuable reminder of the contributions we must all make to improving the health and well-being of our children.

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WORD COUNT: 335

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

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HISTORY																												
Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•[5]	•	•	•	•	•	•	•	•
MEASUREMENTS																												
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Vision	S	S	S	S	S	S	S	S	S	S	S	O[5]	O	O	S	S	O	S	O	S	S	O	S	S	O	S	S	S
Hearing[6]	S/O	S	S	S	S	S	S	S	S	S	S	O	O	O	S	S	O	S	O	S	S	O	S	S	O	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT[7]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[8]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES – GENERAL[9]																												
Hereditary/Metabolic Screening[10]	←	←	•																									
Immunization[11]	•	→		•	•	•		←	→				←	→				•	→									
Lead Screening[12]							•	→			•																	
Hematocrit or Hemoglobin			←				•											←				13					→	
Urinalysis														•				←				14					→	
PROCEDURES – PATIENTS AT RISK																												
Tuberculin Test[15]								*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Cholesterol Screening[16]											*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
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Pelvic Exam[18]																		*	*	*	*	*	*	←	*	18	*	→
ANTICIPATORY GUIDANCE[19]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention[20]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
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1. Breastfeeding encouraged and instruction and support offered.
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18. All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
19. Appropriate discussion and counseling should be an integral part of each visit for care
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21. Earlier initial dental evaluations may be appropriate for some children Subsequent examinations as prescribed by dentist.

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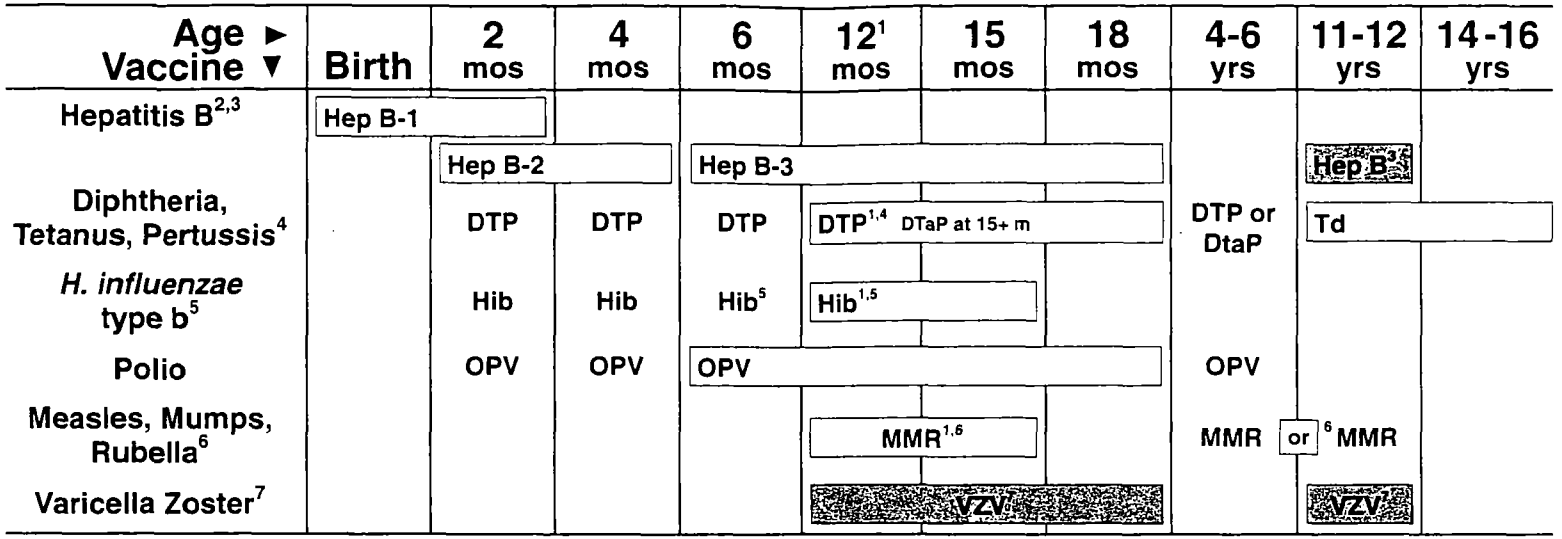
NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc.) is discretionary with the physician.

Recommended Ages for Administration of Currently Licensed Childhood Vaccines - August 1995

Vaccines are listed under the routinely recommended ages. Solid bars indicate range of acceptable ages for vaccination. Shaded bars indicate new recommendations or vaccines licensed since publication of the Recommended Childhood Immunization Schedule in *January 1995. Hepatitis B vaccine is recommended at 11-12 years of age for children not previously vaccinated. Varicella Zoster Virus* vaccine is recommended at 11-12 years of age for children not previously vaccinated, and who lack a reliable history of chickenpox.



1 Vaccines recommended in the second year of life (12-15 months of age) may be given at either one or two visits.

2 **Infants born to HBsAg-negative mothers** should receive 2.5 µg of Merck Sharp & Dohme (MSD) vaccine (Recombivax HB) or 10 µg of SmithKline Beecham (SKB) vaccine (Engerix-B). The second dose should be given between 1 and 4 months of age, if at least one month has elapsed since receipt of the first dose. The third dose is recommended between 6 and 18 months of age.

Infants born to HBsAg-positive mothers should receive immunoprophylaxis for hepatitis B with 0.5 ml Hepatitis B Immune Globulin (HBIG) within 12 hours of birth, and either 5µg of MSD vaccine (Recombivax HB) or 10 µg of SKB vaccine (Engerix-B) at a separate site. In these infants, the second dose of vaccine is recommended at 1 month of age and the third dose at 6 months of age. All pregnant women should be screened for HBsAg in an early prenatal visit.

3 Hepatitis B vaccine is recommended for adolescents who have not previously received 3 doses of vaccine. The 3-dose series should be initiated or completed at the 11-12 year-old visit for persons not previously fully vaccinated. The 2nd dose should be administered at least 1 month after the first dose, and the 3rd dose should be administered at least 4 months after the first dose.

4 The fourth dose of DTP may be administered as early as 12 months of age, provided at least 6 months have elapsed since DTP3. Combined DTP-Hib products may be used when these two vaccines are to be administered simultaneously. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for use for the 4th and/or 5th dose of DTP vaccine in children 15 months of age or older and may be preferred for these doses in children in this age group. Td (tetanus and diptheria toxoids, absorbed, for adult use) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTP-Hib, or DT.

5 Three *H. influenzae* type b conjugate vaccines are available for use in infants: HbOC [HibTITER] (Lederle Praxis); PRP-T [ActHIB; OmniHIB] (Pasteur Mérieux, distributed by SmithKline Beecham; Connaught); and PRP-OMP [PedvaxHIB] (Merck Sharp & Dohme). Children who have received PRP-OMP at 2 and 4 months of age do not require a dose at 6 months of age. After the primary infant Hib conjugate vaccine series is completed, any licensed Hib conjugate vaccine may be used as a booster dose at 12-15 months.

6 The second dose of MMR vaccine should be administered EITHER at 4-6 years of age OR at 11-12 years of age, consistent with state school immunization requirements.

7 Varicella zoster virus vaccine (VZV) is routinely recommended at 12-18 months of age. Children who have not been vaccinated previously and who lack a reliable history of chickenpox should be vaccinated by 13 years of age. VZV can be administered to susceptible children any time after 12 months of age. Children under 13 years of age should receive a single 0.5 mL dose; persons 13 years of age and older should receive two 0.5 doses 4-8 weeks apart.

BECAUSE THE AAP, ACIP AND AAFP HAVE AGREED TO FORMALLY REEVALUATE THE IMMUNIZATION SCHEDULE ANNUALLY, ANY SUBSEQUENT REVISIONS WILL BE PUBLISHED IN THE "RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE / UNITED STATES – JANUARY 1996" IN THE JANUARY 1996 ISSUE OF *PEDIATRICS*.

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OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of the Assistant Secretary for Health
Office of Disease Prevention and Health Promotion
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Washington, D.C. 20201

FACSIMILE TRANSMISSION

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DATE: 8/14/95

TO: Jennifer Klein

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FROM: Carolyn D'Grisepi

Telephone: (202) 205-8660	**FAX #: (202) 205-9478**

MESSAGE:

Recommendations on hearing screening ~~and HIV screening are~~ is not finalized.

CDGrisepi

Ch iii

Table 1.
Birth to 10 Years

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death

Conditions originating in the perinatal period
Congenital anomalies
Sudden Infant Death Syndrome (SIDS)
Unintentional injuries (non-motor vehicle)
Motor vehicle injuries
Malignant neoplasms

INTERVENTIONS FOR THE GENERAL POPULATION

SCREENING
Height and weight [*Ch. 21*]
Blood pressure [*Ch. 3*]
Vision screening (age 3-4 y) [*Ch. 33*]
Hemoglobinopathy screening (birth) [*Ch. 43*]
Phenylalanine level (birth) [*Ch. 44*]
T4 and/or TSH (birth) [*Ch. 45*]

IMMUNIZATIONS [*Ch. 65*]
Diphtheria-tetanus-pertussis (DTP)
Oral poliovirus (OPV)
Measles-mumps-rubella (MMR)
Haemophilus influenzae type b (Hib) conjugate
Hepatitis B
Varicella

CHEMOPROPHYLAXIS
Ocular prophylaxis (birth) [*Ch. 27*]

PATIENT/PARENT COUNSELING
Injury prevention [*Ch. 57, 58*]
Child safety car seats (age < 5 y)
Lap-shoulder belts (age ≥ 5 y)
Bicycle helmet; avoidance of bicycling near traffic
Smoke detector
Flame retardant sleepwear
Hot water heater temperature < 120°F/130°F
Window & stair guards, pool fence
Safe storage of drugs, toxic substances, firearms & matches
Syrup of ipecac, poison control telephone number
CPR training for parents

Diet and Exercise
Encourage breast-feeding & use of iron-enriched formula and foods (infants & toddlers) [*Ch. 22, 56*]
Limit dietary fat & cholesterol, maintain caloric balance, emphasize grains, fruits, vegetables & dry beans (age ≥ 2 y) [*Ch. 56*]
Regular physical activity [*Ch. 55*]

Substance Use [*Ch. 54*]
Effects of passive smoking
Anti-tobacco message

Dental [*Ch. 61*]
Regular dental visits
Regular flossing and brushing with fluoride toothpaste
Advice about baby bottle tooth decay

INTERVENTIONS FOR HIGH-RISK POPULATIONS

POPULATION	POTENTIAL INTERVENTIONS (See detailed high-risk definitions)

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POPULATION	POTENTIAL INTERVENTIONS (See detailed high-risk definitions)
Preterm or low birth weight infants	Hemoglobin/hematocrit (HR1)
Infants of mothers at risk for HIV	HIV testing (HR2)
Low income; immigrants from developing countries	Hemoglobin/hematocrit (HR1); PPD (HR3)
Tuberculosis contacts; homeless or living in a shelter	PPD (HR3)
Native American/Alaskan Native	Hemoglobin/hematocrit (HR1); PPD (HR3); Hepatitis A vaccine (HR4); Pneumococcal vaccine (HR5)
Travelers to developing countries	Hepatitis A vaccine (HR4)
Residents of long-term care facilities	PPD (HR3); Hepatitis A vaccine (HR4); Influenza vaccine (HR6)
Certain chronic medical conditions	PPD (HR3); Pneumococcal vaccine (HR5); Influenza vaccine (HR6)
Increased individual or community lead exposure	Blood lead level (HR7)
Inadequate water fluoridation	Daily fluoride supplement (HR8)
Family h/o skin cancer; nevi; fair skin, eyes, hair	Avoid excess/midday sun, use protective clothing (HR9)

Whether screening should be universal or targeted to high-risk groups will depend on the proportion of high-risk individuals in the screening area, the accuracy and efficiency with which infants at risk can be identified, and other characteristics of the screening program.

If done during first 24 hrs of life, repeat by age 2 wks.

Optimally between day 2 and 6, but in all cases before newborn nursery discharge.

2, 4, 6, and 12–18 mo; once between ages 4–6 yr (DTaP may be used after 15 mo).

2, 4, 6, 18 mo; once between ages 4–6 yr.

12–15 mo and 4–6 yr.

2, 4, 6, and 12–15 mo; no dose needed at 6 mo if PRP-OMP vaccine is used for first 2 doses.

Birth, 1 mo, 6 mo; or 0–2 mo, 1–2 mo later, and 6–18 mo. If not done in infancy: current visit, and 1 and 6 mo later.

12–18 mo; or any child without hx of chickenpox or previous immunization. Include information on risk in adulthood, duration of immunity, and potential need for booster dose.

The ability of clinician counseling to influence this behavior is unproven.

Table 1

High-Risk Codes, Table 1. Birth–10 Years

HR1 = Infants age 6–12 mo who are: living in poverty, black, Native American and Alaskan Natives, immigrants from developing countries, preterm and low birth weight infants, infants whose principal dietary intake is unfortified cow's milk (see Ch. 22).

HR2 = Infants born to high-risk mothers when mother's HIV status is not known. Women at high risk for HIV include: past or present injection drug use; persons who exchange sex for money or drugs, and their sexual partners; injection drug-using, bisexual and HIV-positive sexual partners currently or in past; persons seeking treatment for sexually transmitted diseases; blood transfusion during 1978–1985 (see Ch. 28).

HR3 = Persons infected with HIV, close contacts of persons with known or suspected TB (including health care workers), persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence (e.g., most countries in Africa, Asia, and Latin America), medically underserved low-income populations (including high-risk racial or ethnic minority populations), residents of long-term care facilities (see Ch. 25). Also see Ch. 25 for indications for BCG vaccine.

HR4 = Persons ≥2 y living in or traveling to areas where the disease is endemic and where periodic outbreaks occur (e.g., international travelers to countries with high or intermediate endemicity; certain Alaskan Native, Pacific Island, and Native American communities, and certain religious communities). Vaccine may be considered for institutionalized children ≥2 y. Clinicians should consider local epidemiology of the disease in identifying high-risk groups (see Ch. 65–66, 67).

HR5 = Immunocompetent persons ≥2 y with certain medical conditions, including chronic cardiac or pulmonary disease, diabetes mellitus, and anatomic asplenia. Immunocompetent persons ≥2 y living in special environments or social settings with an identified increased risk of pneumococcal disease (e.g., certain Native American and Alaskan Native populations) (see Ch. 66).

HR6 = Annual vaccination of children ≥6 mo who are residents of chronic care facilities, or have chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction (see Ch. 66). See Ch. 66 for indications for the use of amantadine and rimantadine prophylaxis against influenza A.

HR7 = Children age 12 mo who are: 1) living in communities in which the prevalence of lead levels requiring individual intervention, including residential lead hazard control or chelation, is high or undefined; 2) living in or frequently visiting a home built before 1950 with dilapidated paint or with recent ongoing renovation or remodeling; 3) having close contact with a person who has an elevated lead level; 4) living near lead industry or heavy traffic; 5) living with someone whose job or hobby involves lead exposure; 6) using lead-based pottery; or 7) taking traditional ethnic remedies that contain lead (see Ch. 23).

HR8 = Children living in areas with inadequate water fluoridation (<0.6 ppm) (see Ch. 61).

HR9 = Persons with a family history of skin cancer, a large number of moles, poor tanning ability, or light skin, hair, and eye color (see Ch. 12).

Table 2.
11–24 Years

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death

Motor vehicle and other unintentional injuries
Homicide
Suicide
Malignant neoplasms
Heart diseases
Human immunodeficiency virus (HIV) infection

INTERVENTIONS FOR THE GENERAL POPULATION

SCREENING
Height and weight *[Ch. 21]*
Blood pressure *[Ch. 3]*
Papanicolaou (Pap) testing (females) *[Ch. 9]*
Chlamydia screen (females < 21 y) *[Ch. 29]*
Rubella serology or vaccination hx (females > 12 y) *[Ch. 32]*
Assess for problem drinking *[Ch. 52]*

IMMUNIZATIONS *[Ch. 65, 66]*
Tetanus-diphtheria (Td) boosters (begin age 11–16 y)
Hepatitis B vaccine
MMR (11–12 y)
Varicella (11–12 y)
Offer rubella vaccination (females > 12 y) *[Ch. 32]*

CHEMOPROPHYLAXIS
Multivitamin with folic acid (women planning or capable of pregnancy) *[Ch. 42]*

PATIENT COUNSELING
Injury prevention *[Ch. 57, 58]*
Lap-shoulder belts
Motorcycle helmets
Bicycle/ all-terrain vehicle helmets
Smoke detector
Safe storage or removal of firearms *[Ch. 50, 59]*

Substance Use
Tobacco avoidance *[Ch. 54]*
Avoid alcohol & other drug use while driving, swimming, boating, bicycling, and hunting* *[Ch. 57, 58]*
Avoid use of contaminated injection needles *[Ch. 62]*

Sexual Behavior
~~Sexually transmitted disease~~ prevention: avoid high-risk sexual behavior; use condoms, female barrier contraceptive with spermicide *[Ch. 62]*
Contraceptive use to prevent unintended pregnancy *[Ch. 63]*

Diet and Exercise
Limit dietary fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables, & dry beans *[Ch. 56]*
Regular physical activity *[Ch. 55]*

Dental *[Ch. 61]*
Regular visits to dental provider
Floss and brush teeth daily with fluoride toothpaste

INTERVENTIONS FOR HIGH-RISK POPULATIONS

POPULATION (See detailed high-risk definitions)	POTENTIAL INTERVENTIONS
High-risk sexual behavior	RPR/VDRL (HR1); screen for Gonorrhea (female) (HR2), HIV (HR3), → Chlamydia (female) (HR4); Hepatitis A vaccine (HR5)

High-risk sexual behavior	RPR/VDRL (HR1); screen for Gonorrhea (female) (HR2), HIV (HR3), Chlamydia (female) (HR4); Hepatitis A vaccine (HR5)
Injection or street drug users	RPR/VDRL (HR1); HIV screen (HR3); Hepatitis A vaccine (HR5); PPD (HR6)
Tuberculosis contacts; immigrants from developing countries; low income; HIV positive; homeless	PPD (HR6)
Native Americans/ Alaskan Natives	Hepatitis A vaccine (HR5); PPD (HR6); Pneumococcus vaccine (HR7)
Travelers to developing countries	Hepatitis A vaccine (HR5)
Certain chronic medical conditions	PPD (HR6); Pneumococcus vaccine (HR7); Influenza vaccine (HR8)
Settings where adolescents and young adults congregate	Second MMR (HR9)
Susceptible to varicella, measles, mumps	Varicella (HR10); MMR (HR11)
Blood transfusion between 1975/85	HIV screen (HR3)
Institutionalized persons	Hepatitis A vaccine (HR5); PPD (HR6); Influenza vaccine (HR8)
Health care/lab workers	Hepatitis A vaccine (HR5); PPD (HR6); Influenza vaccine (HR8)
Family h/o skin cancer; nevi; fair skin, eyes, hair	Avoid excess/midday sun, use protective clothing (HR12)
Prior pregnancy with neural tube defect	Folic acid 4.0 mg (HR13)
Inadequate water fluoridation	Daily fluoride supplement (HR14)

Table 2

NB pneumococcus is not capitalized or italicized

✓Periodic BP for persons ≥ 21 years.
✓If sexually active at present or in the past: q ≤ 3 y. If sexual history is unreliable, begin Pap tests at age 18 y.
✓If sexually active.
✓Serology testing, documented vaccination history, and routine vaccination against rubella (preferably with MMR) are equally acceptable alternatives.
✓If not previously immunized: current visit, 1 m and 6 m later.
✓Second MMR if no previous second dose.
✓If susceptible to chickenpox.
✓Evidence is based on folic acid as a component of a multivitamin/multimineral or multivitamin supplement.

✓The ability of clinician counseling to influence this behavior is unproven.

High Risk Codes, Table 2. 11-24 Years

HR1 = Persons who exchange sex for money or drugs, and their sexual partners; persons with other STDs (including HIV); and sexual contacts of persons with active syphilis. The local epidemiology of syphilis in the community and the number of sexual partners reported by an individual should also be considered in identifying other persons at high risk of infection (see Ch. 26).

HR2 = Women under age 25 with two or more sexual partners in the last year, or whose sexual partner has multiple sexual contacts; females who exchange sex for money or for drugs, and women with a history of repeated episodes of gonorrhea. Actual risk will depend on local epidemiology of disease (see Ch. 27).

HR3 = Males who had sex with males after 1975; past or present injection drug use; persons who exchange sex for money or drugs, and their sexual partners; injection drug-using, bisexual, or HIV-positive sexual partner currently or in the past; blood transfusion during 1978-1985 (includes patients with hemophilia); persons seeking treatment for ~~sexually transmitted diseases~~ STDs (see Ch. 28).

HR4 = Sexually active women with multiple risk factors including: history of prior STD; new or multiple sexual partners; age under 25; inconsistent use of barrier contraceptives; single marital status. Clinicians should consider local epidemiology of the disease in identifying high-risk groups (see Ch. 29).

HR5 = Persons living in or traveling to areas where the disease is endemic and where periodic outbreaks occur (e.g., international travelers to countries with high or intermediate endemicity; certain Alaskan Native, Pacific Island, and Native American communities, certain religious communities); men who have sex with men; injection or street drug users. Vaccine may be considered for institutionalized persons, ~~the~~ military, and hospital and laboratory personnel. Clinicians should consider local epidemiology of the disease in identifying high-risk groups (see Ch. 66,67).

HR6 = HIV positive, close contacts of persons with known or suspected TB, health care workers, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence (e.g., most countries in Africa, Asia, and Latin America), medically underserved low-income populations, homeless or living in a shelter, alcoholics, injection drug users, and residents of long-term care facilities (see Ch.25). See also Ch. 25 for indications for BCG vaccine.

HR7 = Immunocompetent persons with certain medical conditions, including chronic cardiac or pulmonary disease, diabetes mellitus, and anatomic asplenia. Immunocompetent persons who live in special environments or social settings with an identified increased risk of pneumococcal disease (e.g., certain Native American and Alaskan Native populations) (see Ch. 66).

HR8 = Annual vaccination of residents of chronic care facilities, and persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction; and health care providers for high-risk patients (see Ch. 66). See Ch. 66 for indications for amantadine/rimantadine prophylaxis against influenza A.

HR9 = Adolescents and young adults in settings where such individuals congregate (e.g., high schools and colleges), if they have not previously received a second dose (see Ch. 65,66).

HR10 = Healthy persons ≥13 y without h/o varicella infection or previous immunization. Serologic testing may be considered for presumed susceptible persons ≥13 y because most such persons are in fact immune (see Ch 65,66).

HR11 = Persons born after 1956 who lack evidence of immunity to measles or mumps. Examples of such evidence include receipt of live vaccine on or after the first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles or mumps (see Ch. 66).

HR12 = Persons with a family or personal history of skin cancer, a large number of moles, poor tanning ability, or light skin, hair, and eye color (see Ch. 12).

HR13 = Women with history of prior pregnancy affected by neural tube defect who are planning pregnancy (see Ch. 42).

HR14 = Children <17 y living in areas with inadequate water fluoridation (<0.6 ppm) (see Ch. 61).

COVER SHEET

FAX

To: Jennifer Klein
Fax #: 202-456-2878
Subject: pediatrics
Date: August 14, 1995
Pages: 3, including this cover sheet.

COMMENTS:

Here is a summar of the periodicity from the AAP (I had them fax me the same document) and the page from Bright Futures. According to Karen, they differ only slightly, and not really on the timing of the visit, but more what you do in each one.

Call prn questions, and see you Wednesday!

From the desk of...

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Fax: 301-594-2168

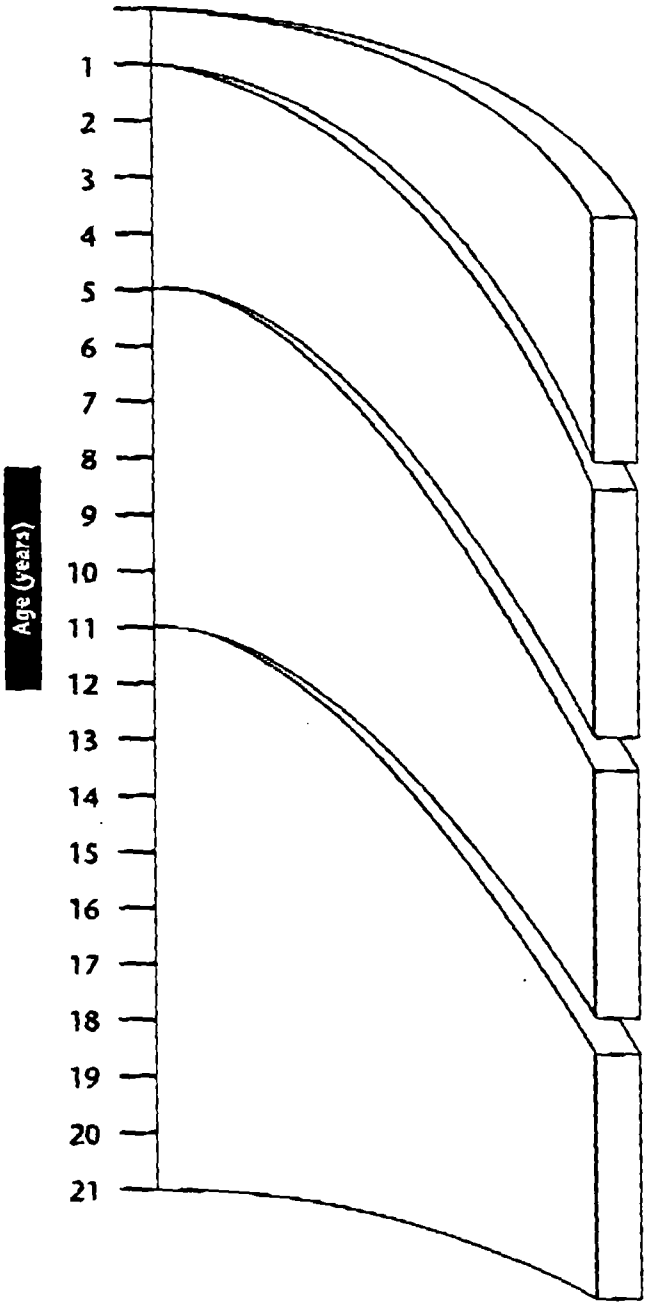
AAP Recommendations as of August 1995 (new committee report about to come out - i.e. "hot off the press"

Periodicity of visits:

newborn
2 to 4 days
by 1 mo
then at the following months: 2, 4, 6, 9, 12, 15, 18, 24.
Then at the following years: 3, 4, 5, 6, 8, 10.
Then every year from 10 through 21 years.

According to Bright Futures, the timing is basically same (see attached).

Appendix A: Bright Futures Periodicity Schedule



INFANCY PERIODICITY SCHEDULE

Prenatal	2 Months
Newborn	4 Months
First Week	6 Months
1 Month	9 Months

EARLY CHILDHOOD PERIODICITY SCHEDULE

1 Year	2 Years
15 Months	3 Years
18 Months	4 Years

MIDDLE CHILDHOOD PERIODICITY SCHEDULE

5 Years	8 Years
6 Years	10 Years

ADOLESCENCE PERIODICITY SCHEDULE

11 Years	17 Years
12 Years	18 Years
13 Years	19 Years
14 Years	20 Years
15 Years	21 Years
16 Years	