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SUSPECTED OPIOID OVERDOSE

Background Information

Naloxone is a proven tool in the battle against drug abuse and overdose death. Overdose death can occur when too much of an opioid medication is taken resulting in a dangerously low respiratory rate. Naloxone is an opioid antagonist reversing the effects of the drug including respiratory depression and sedation by competing with the opiate receptors in the CNS. Naloxone ONLY works if a person has opioids in their system; it is not effective against respiratory depression due to non-opioid drugs. Naloxone does not produce tolerance to the opioid antagonist effect or physical dependence.

SUBJECTIVE

History of:

Known or suspected opioid use

Report by family or friends of recent opioid use

Unknown patient history should not prevent medical management of suspected opioid overdose

Symptoms:

Loss of consciousness

Choking sounds, or a snore-like gurgling noise

Body is very limp

Face is very pale or clammy

Fingernails and lips turn blue or purplish black

OBJECTIVE

Unresponsive to outside stimulus

Breathing is very slow and shallow, erratic, or has stopped

(The best predictor of opioid poisoning is a respiratory rate <12)

Pulse (heartbeat) is slow, erratic, or not there at all

Pinpoint pupils

ASSESSMENT

Possible opioid overdose

PLAN

- Attempt to awake with sternal rub
- Activate emergency response system
- Perform rescue breathing if necessary

Dosing for adults and children weighing \geq 8 pounds

- Administer naloxone 0.4mg/mL 1cc INTRAMUSCULARLY in the deltoid or anterolateral thigh (always administer in the anterolateral thigh if <1 year old)
- If there is no response or inadequate response (respiratory rate remains below 12 breaths per minute AND patient is still unresponsive) after 2 – 3 minutes, administer a second Naloxone 0.4 mg IM dose.

Dosing for children weighing < 8 lbs

Administer initial Naloxone dose of 0.1 mg/kg IM in the anterolateral thigh muscle

Infant weight	Naloxone Dose	Amount to administer based on 0.4 g/ml Naloxone stock vial
6-8 lbs	0.3 mg	0.75 ml
4-5 lbs	0.2 mg	0.5 ml
< 3 lbs	0.1 mg	0.25 ml

The goal of naloxone administration is **NOT** a normal level of consciousness, but adequate ventilation.

- If desired response is not achieved, repeat dosing every 2 to 3 minutes as needed until emergency medical assistance arrives or until Naloxone supply is depleted
- If normal breathing resumes, place in rescue position and administer oxygen
- Remain with patient until EMS arrives
- If not breathing adequately, resume rescue breathing
- Naloxone will wear off within 1-2 hours so encourage patient to go to ER

There are no medical contraindications to administering Naloxone to prevent opioid overdose death. This includes administering to pregnant women.

Precautions

Administration of naloxone may precipitate symptoms of acute withdrawal which may include pain, tachycardia, hypertension, fever, sweating, abdominal cramps, diarrhea, nausea, vomiting, AGITATION, AND IRRITABILITY. This typically occurs with IV administration due to the rapid onset of action.

REFERENCES

Coffin, P., Prevention of Lethal Opioid Overdose in the Community. In: UpToDate, Saxon, AJ (Ed), UpToDate, Waltham, MA, 2016

Naloxone: Drug information. In UpToDate, Waltham, MA, accessed January 21, 2016

Stolbach, A., Hoffman, R., Acute Opioid Intoxication in Adults. In: UpToDate, Traub, S.(Ed), UpToDate, Waltham, MA 2016

TDH Naloxone webpage <http://tn.gov/health/topic/information-for-naloxone>

Yin, S., Opioid Intoxication in Children and Adolescents. In: UpToDate, Burns, M., (Ed), UpToDate, Waltham, MA 2016

Community Located Vaccination Clinics

The Emergency Protocols below for Anaphylaxis and Syncope are to be used during community located vaccination clinics

ANAPHYLAXIS

SUBJECTIVE

History of:

- Recent injection, often within minutes
- Previous allergic reaction

Symptoms may include:

- Headache
- Anxiety/feeling of impending doom
- Difficult breathing/tightness in throat and chest, wheezing
- Feeling faint
- Localized or generalized pruritus
- Swelling of hands, feet, face and tongue

OBJECTIVE

- Weak, irregular, and rapid pulse (above 100 beats per minute)
- Rapid and shallow respirations
- Fall in blood pressure
- Patient apprehensive and perspiring heavily, may be confused
- Lips, tongue, and eyelids are frequently swollen
- Hives, rash, erythema
- Cyanosis of the lips and nail beds
- Labored breathing and wheezing (wheezes are heard throughout chest)
- Nasal discharge, nasal congestion, change in voice quality, sensation of throat closure or choking, shortness of breath

ASSESSMENT

- Anaphylactic reaction

PLAN

There are **NO** absolute contraindications to epinephrine use in anaphylaxis:

- Initiate emergency response system
- Place patient in supine position
- Assure adequate airway - administer CPR if indicated
- Question regarding most recent weight

Administer aqueous epinephrine 1:1000 INTRAMUSCULAR according to Emergency Drug Chart A
 May repeat epinephrine dosage every 5-15 minutes, if necessary

EMERGENCY DRUG CHART

Aqueous Epinephrine (Adrenaline) = 0.01 ml./kg. IM

Epinephrine Dose

Recommended dose is 0.01 mg/kg body weight up to 0.5 mg maximum dose.

May be repeated every 5–15 minutes for a total of 3 doses.

Age group	Range of weight (kg)*	Range of weight (lb)	1 mg/mL injectable (1:1000 dilution); <u>INTRAMUSCULAR</u> Minimum dose: 0.05 mL
1–6 months	4–8.5 kg	9–19 lb	0.05 mL (or mg)
7–36 months	9–14.5 kg	20–32 lb	0.1 mL (or mg)
37–59 months	15–17.5 kg	33–39 lb	0.15 mL (or mg)
5–7 years	18–25.5 kg	40–56 lb	0.2–0.25 mL (or mg)
8–10 years	26–34.5 kg	57–76 lb	0.25–0.3 mL (or mg)
11–12 years	35–45 kg	77–99 lb	0.35–0.4 mL (or mg)
13 years & older	46+ kg	100+ lb	0.5 mL (or mg) – max.

NOTE: Dosing by weight is preferred. If weight is not known or not readily available, dosing by age is appropriate.

SYNCOPE/VASOVAGAL REACTION/COMMON FAINT

SUBJECTIVE

Symptoms may include:

Nausea
 Lightheadedness
 Roaring in ears sensation
 Dimming vision

History to establish cause:

Gather as much information as possible from patient, family/friend(s), or bystanders

- What was the person doing prior to the injection?
- What were the prodromal symptoms (i.e., nausea, lightheadedness etc.)?

- Are there any predisposing factors (i.e., age, chronic disease, fasting?)
- Are there any precipitating factors (i.e., a painful or fearful procedure)?
- What did others witness?
- Were there any signs of seizure?

OBJECTIVE

Diaphoresis
Loss of color (pale/ashen)
Loss of consciousness and postural tone

ASSESSMENT

Syncope – Possible Vasovagal Reaction

PLAN

Assure airway, breathing, and circulation
Remove any inciting stimuli (stress, pain, fear, etc.)
Elevate legs, loosen tight clothing such as a tie or belt
Monitor vital signs
When there is immediate recovery, review history and refer patients with any significant findings to a primary care provider
Initiate emergency response (call EMT/911) if recovery is not complete within minutes
Continue to check vital signs, assure airway, breathing, and circulation until EMT arrives
Give report to EMT team

REFERENCES

Community Health Services Policy #3.4A

<http://www.mayoclinic.org/diseases-conditions/vasovagal-syncope/diagnosis-treatment/treatment/txc-20184861>, accessed May 17, 2016.

Simons, F., MD, FRCPC. Anaphylaxis: Rapid Recognition and Treatment. In: UpToDate, Feldweg, A., (Ed), UpToDate, Waltham, MA, 2016

CERVICAL CANCER SCREENING PROCEDURE

The Tennessee Department of Health has several programs such as Family Planning, Breast and Cervical Cancer Screening and Women's Health that offer cervical cancer screening beginning at age 21.

Clients should be prepared for cervical cancer screening by being given the following information prior to the day of pap smear:

- Avoid douching for 2 days before the examination
- Avoid putting **ANYTHING** into the vagina for 2 days before the exam (optimal)
- Make appointment for Pap test 1-2 weeks after the end of menses (optimal)
- Whenever possible, have abnormal vaginal secretions treated before a Pap test is scheduled

SUBJECTIVE

The client reports to a program or service within the health department that could include cervical cancer screening.

OBJECTIVE

The client meets the screening criteria established according to ASCCP (American Society for Colposcopy and Cervical Pathology) guidelines .

ASSESSMENT

The client is appropriate for cervical cancer screening. The timing of her screening test is based upon her age and/or history and/or the results of her last Pap test.

PLAN

- Review the Pap history in the chart.
- Based on history, prepare the necessary materials for a Pap test. If a pap test is not done, document reason in the chart.
- Explain to the client how she will receive her Pap results. Provide Reproductive Health Teaching (see below).
- Schedule for next appointment
- Complete follow-up for the Pap results as directed. (see written order of provider and Family Planning Guidelines)

HEALTH TEACHING

- Explain that nearly all sexually active individuals will be exposed to HPV sometime in their lifetime; 80% by age 50. Most women will have a natural immune response and clear the HPV on their own. Only a few at risk individuals will eventually develop cervical cancer from HPV exposure. This process takes many years. Therefore, cervical cancer screening must continue throughout a woman's life.
- Assess client's current immunization status including HPV vaccine. Offer vaccine(s) based on current vaccine guidelines.
- Provide an overview of all sexually transmitted infections.

- Promote and instruct in the correct use of condoms.
- Review the risks associated with the following high-risk sexual behaviors:
 - Unprotected intercourse, including oral and anal sex
 - Early onset of sexual intercourse (i.e., first sexual intercourse before the age of 18) including increased likelihood of exposure to STDs and the increased risk of teen pregnancy and unintended pregnancy. Both teen pregnancy and unintended pregnancy are associated with infant mortality and morbidity.
 - Multiple sexual partners.
 - Having a sexual partner who has multiple partners.
 - Numerous sexual partners in a lifetime (serial monogamy).
- Review the increased risk of cervical cancer in women who smoke cigarettes.
- Review the risk to daughters of women who took the hormone diethylstilbestrol (DES) during their pregnancies (for clients born before 1970, DES was used primarily to prevent repeat miscarriages). These daughters are at greater risk for developing vaginal and cervical cancers.

FAMILY PLANNING GUIDELINES GENERAL INFORMATION

How Do We Screen For Cervical Cancer?

The Tennessee Department of Health screens women for cervical cancer using liquid-based cytology (Pap) testing. A benefit of liquid-based testing is to allow for triage of atypical squamous cells of undetermined significance (ASCUS) for presence of HPV without having to bring the client back in to collect another sample.

What is HPV Testing?

Human papilloma virus (HPV) testing refers to the identification of high-risk (oncogenic) HPV strains that can become precursors to cervical cancer. HPV testing is a tool used to determine the need for a colposcopy in women with atypical squamous cells, undetermined significance (ASC-US) results and is referred to as reflex testing. HPV testing is also used in women aged 30-65 as an adjunct to cytology for cervical cancer screening to lengthen the screening interval (if both test are negative); this is referred to as co-testing.

Indications for HPV testing include the following:

- Reflex testing – to determine the need for colposcopy in women with ASC-US cytology result.
- Co-testing – use as an adjunct to cytology for cervical cancer screening in women aged 30 years and older.

Who and When Do We Screen For Cervical Cancer?

Cervical cancer screenings should begin at 21 years old. While a pap test may not be necessary at all Family Planning Program visits, an annual physical exam including but not limited to breast exam and pelvic (visual and bimanual) exam is still recommended. Counsel regarding the importance of preventative services including pap testing.

Summary of Cervical Cancer Screening Guidelines

Population	Recommended Screening Method
Age under 21	Do not screen
Age 21-29	Cytology (Pap smear) every 3 years. Reflex HPV for pap result of ASCUS
Age 30-64	Cytology every 3 years with reflex HPV for ASCUS results or Co-testing (cytology & HPV) every 5 years Note: Clients must be offered both options and allowed to choose based on their preference.
Age 65 and up	Discontinue screening if, since age 55, patient has had 2 consecutive negative HPV tests or 3 consecutive negative cytology results
Hysterectomy with removal of cervix	Screening indicated ONLY for women with a history of either: 1) CIN2+ in the past 20 years, or 2) a history of cervical cancer ever.
Vaccinated against HPV	Follow age-specific recommendations (same as unvaccinated women)

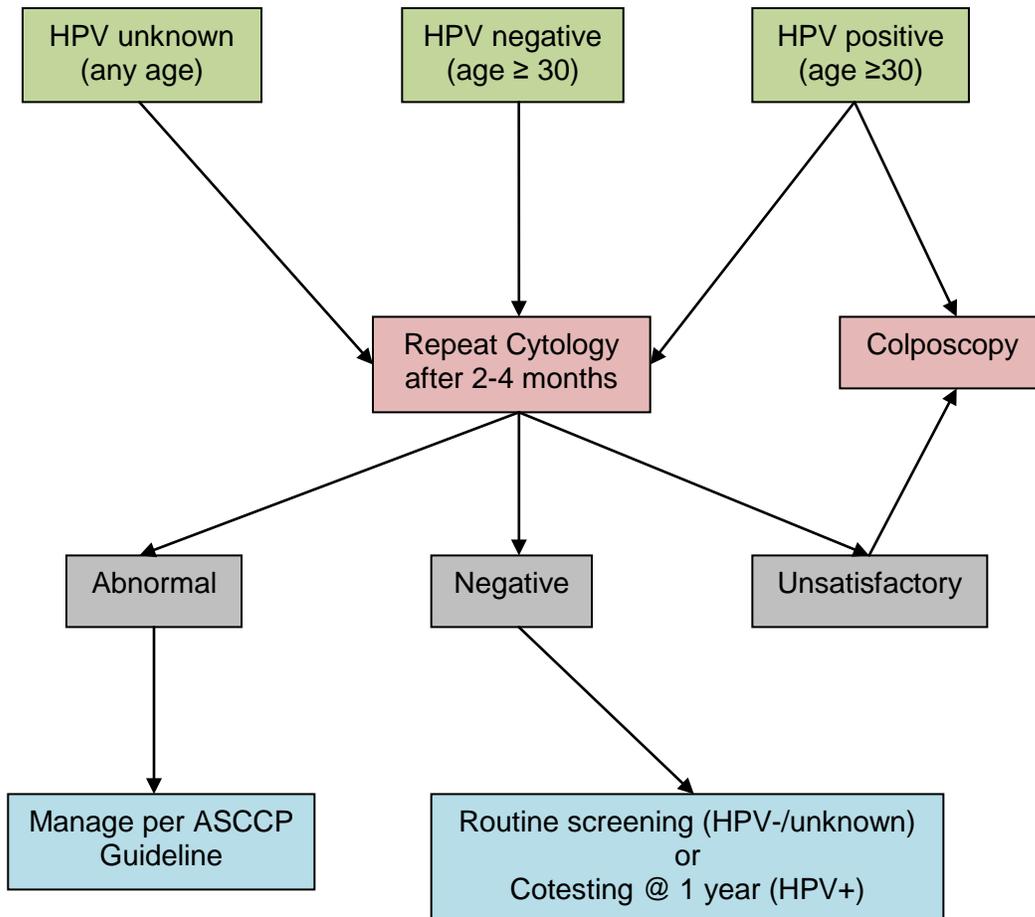
Please note these guidelines do not apply to the following high-risk populations:

- HIV positive: CDC recommends that women with HIV have cervical cytology screening twice in the first year after diagnosis and annually thereafter. Screening should be initiated at the age when diagnosed with HIV even if younger than 21 years old.
- Immunosuppressed: ACOG recommends annual cytology screening starting at age 21, No recommendation exist from the ASCCP.
- Exposure to diethylstilbestrol (DES) in utero: No recommendation exists from ACOG or ASCCP
- Previous treatment for CIN2 or higher: Continue routine age-based screening for 20 years after the initial post treatment surveillance period, even if screening continues past age 65.

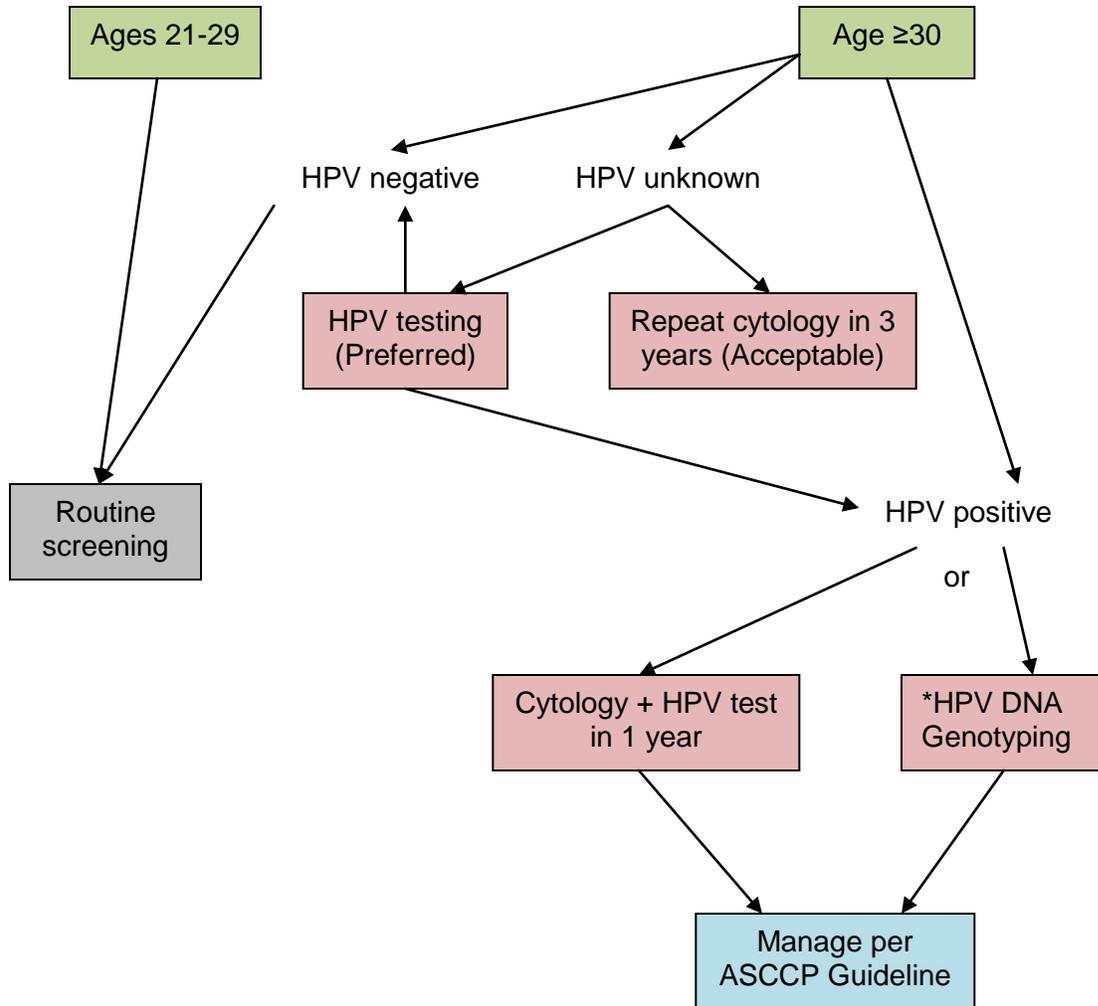
Refer to the following algorithms from American Society for Colposcopy and Cervical Pathology (ASCCP). Full details of these guidelines may be reviewed at ASCCP's

website <http://www.asccp.org/ConsensusGuidelines/UpdatedConsensusGuidelinesAlgorithms/tabid/14410/Default.aspx>

Unsatisfactory Cytology

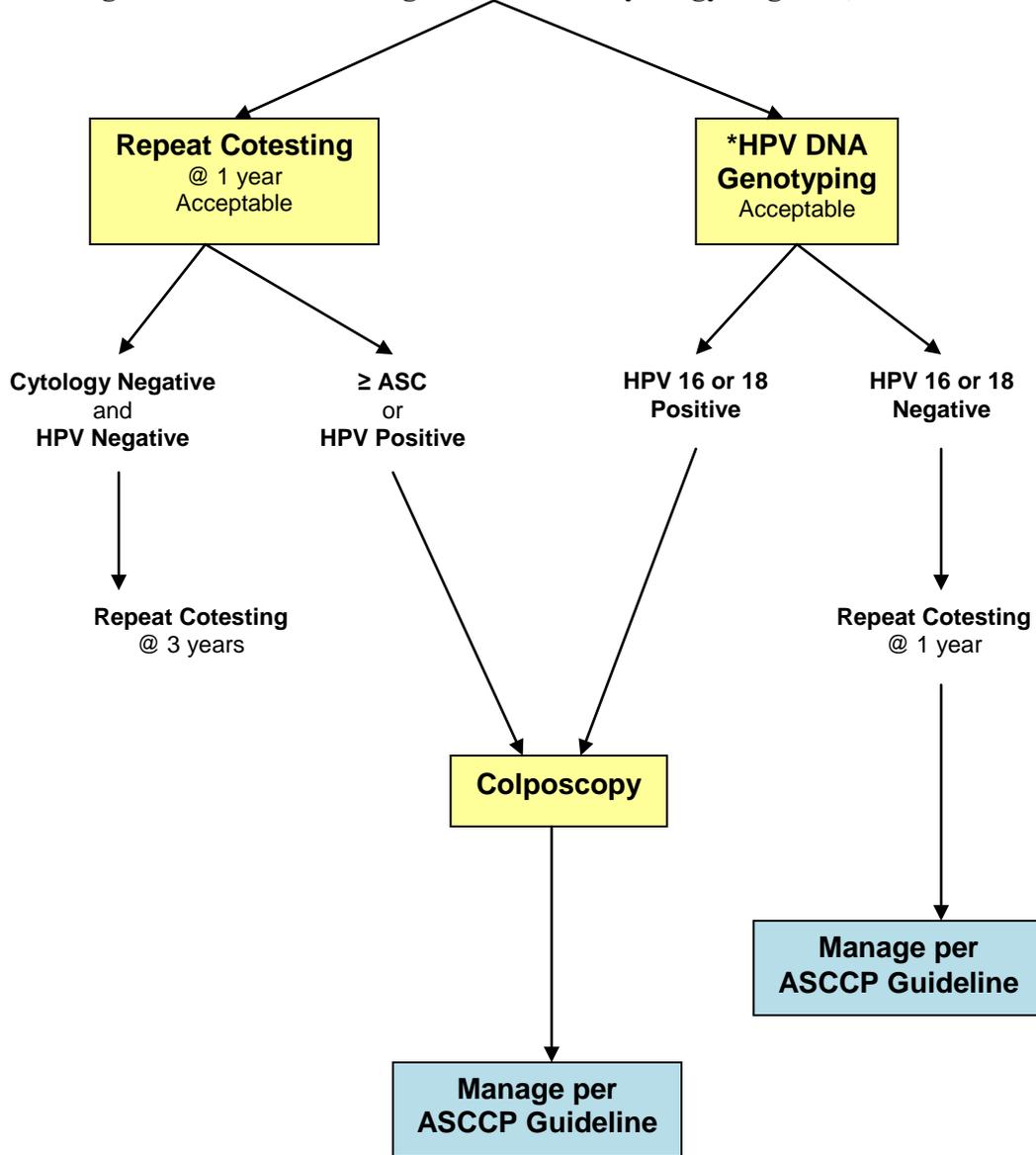


**Cytology Negative for Intraepithelial Lesion or Malignancy (NILM)
but Endocervical/Transformation (EC/TZ) Absent/Insufficient**



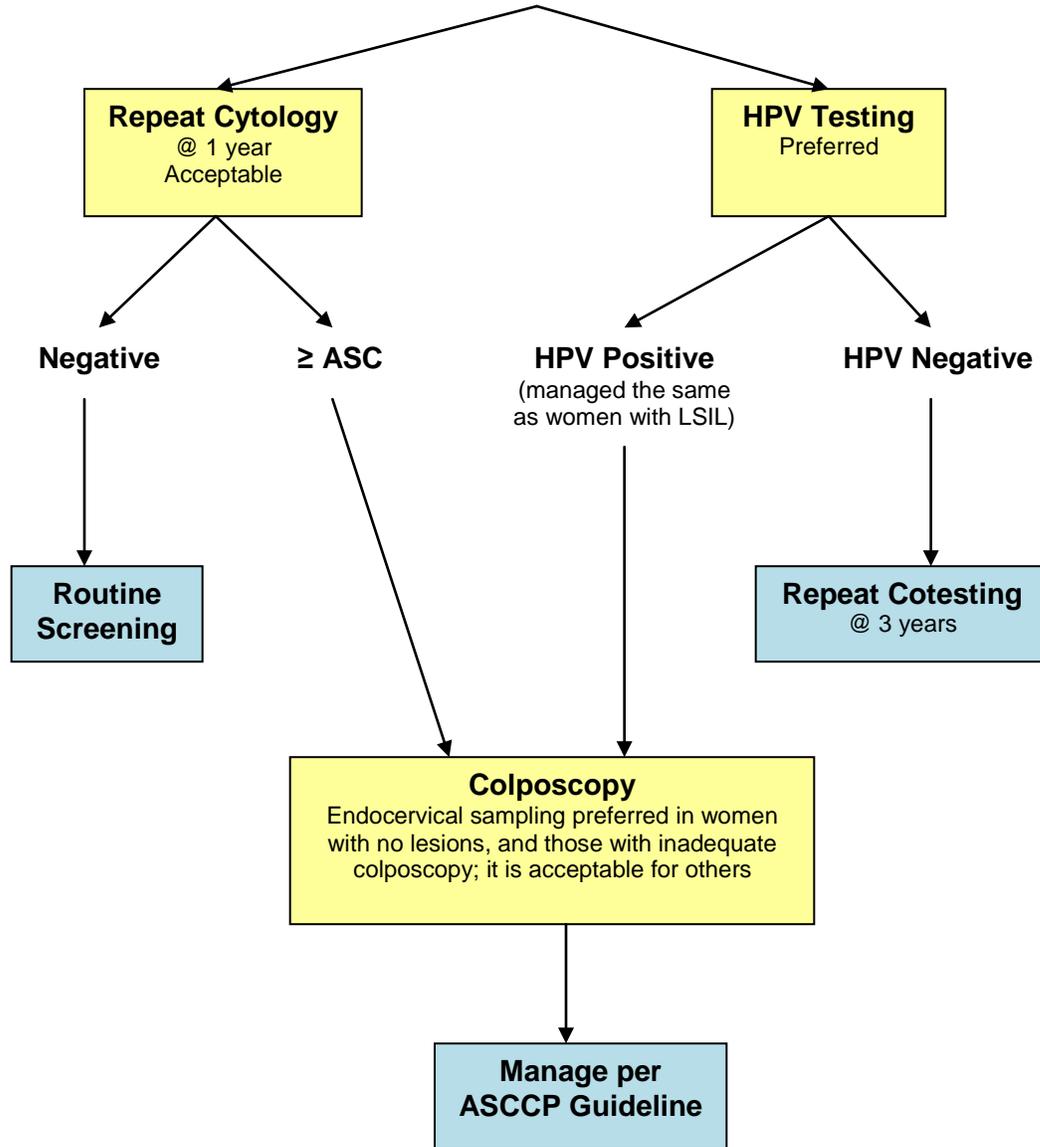
***Family Planning and Breast and Cervical Screening Programs do not currently pay for HPV DNA Genotyping.**

Management of Women \geq Age 30, who are Cytology Negative, but HPV Positive

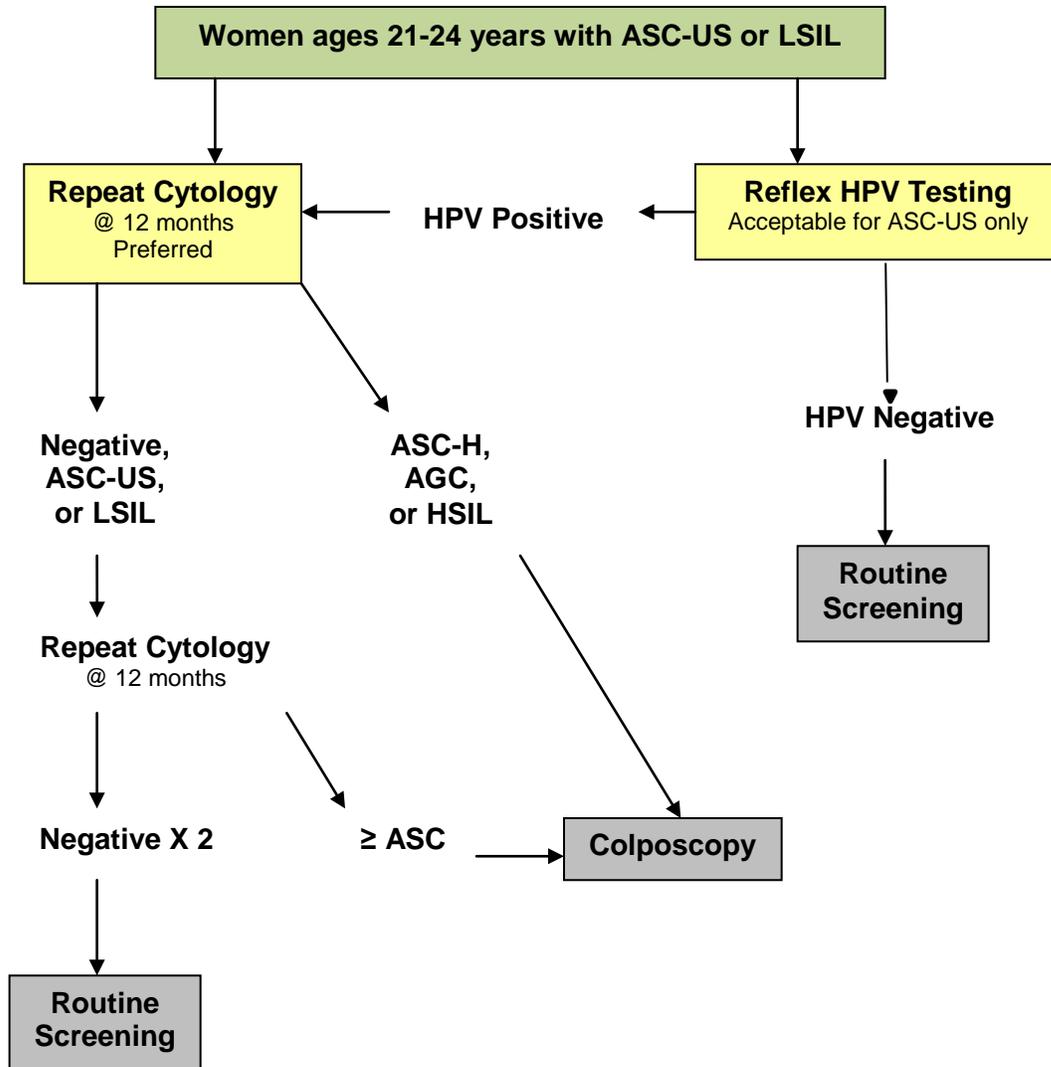


***Family Planning and Breast and Cervical Screening Programs do not currently pay for HPV DNA Genotyping.**

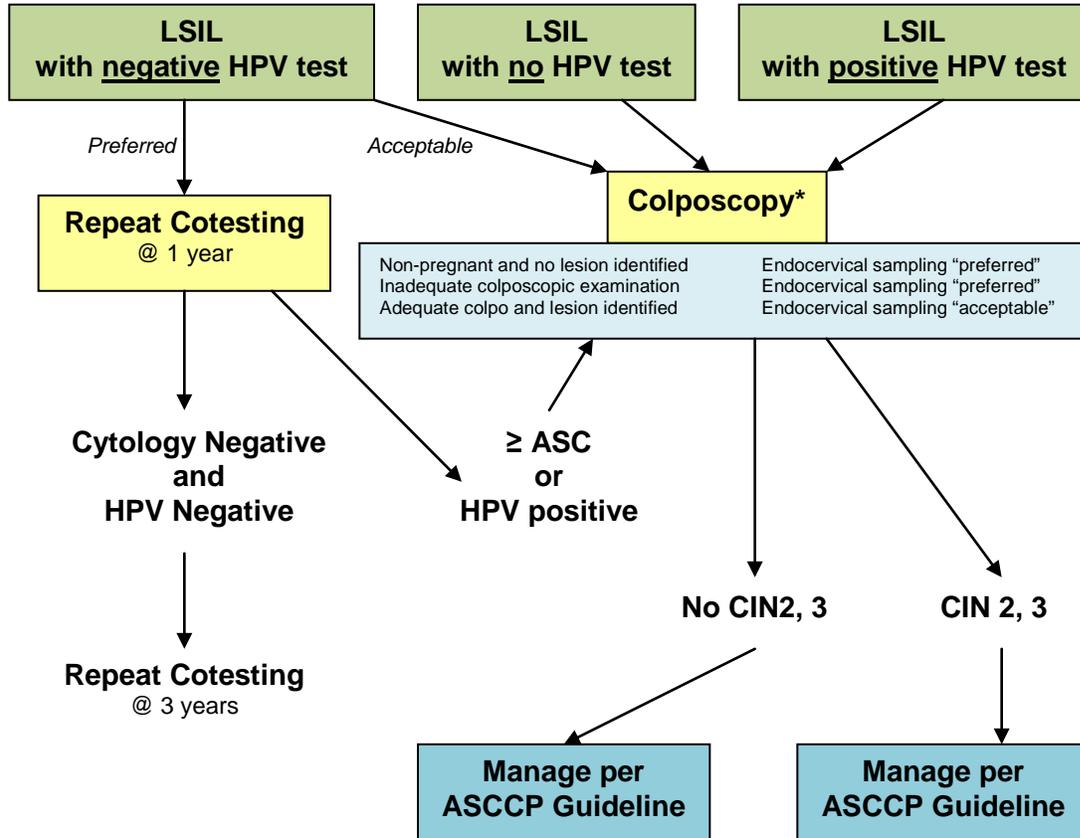
Management of Women > 25 years with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology
 (For women between 21-24 years, see following algorithm.)



Management of Women Ages 21-24 years with either Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)

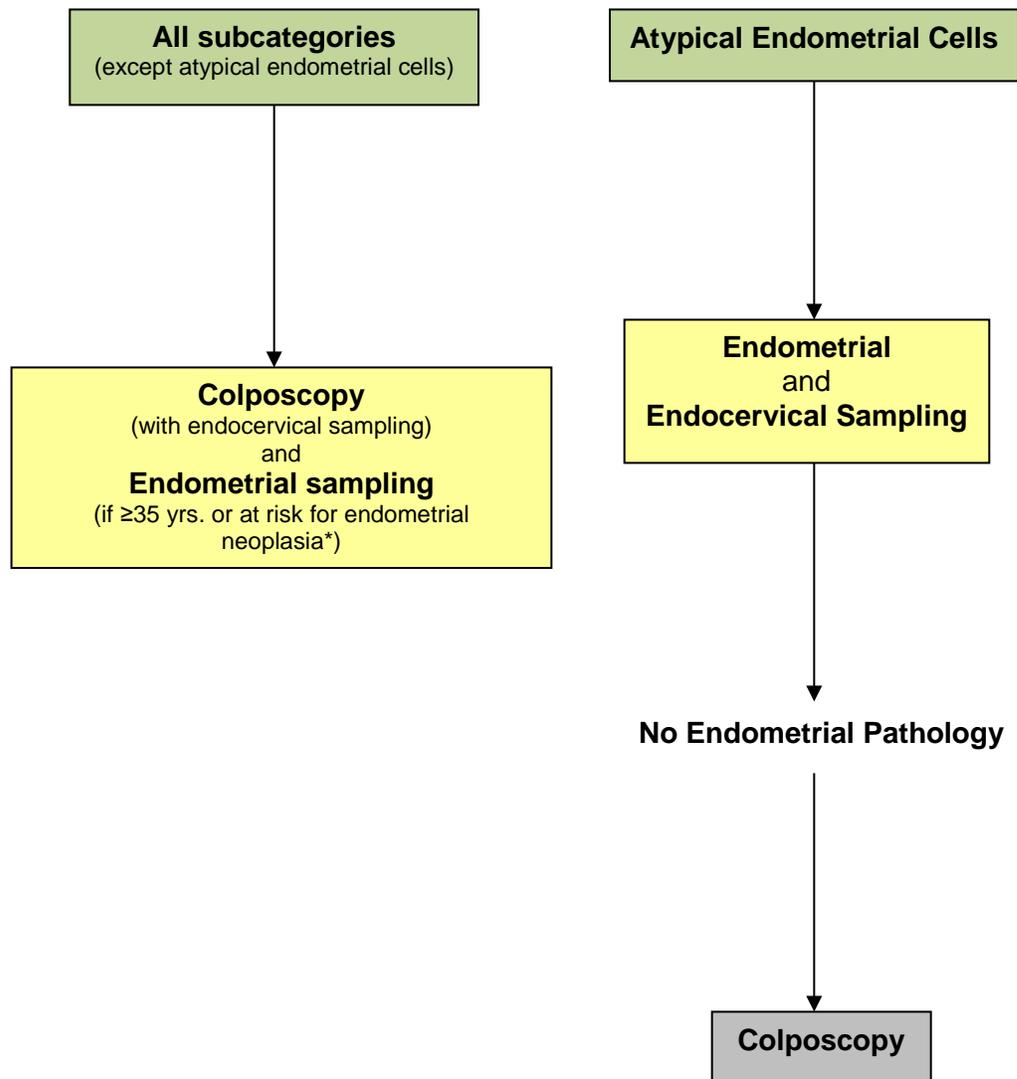


Management of Women >25 years with Low-grade Squamous Intraepithelial Lesions (LSIL)
 (For women between 21-24 years, see previous algorithm.)



***After colposcopy, management is directed by the colposcopist. Refer to the ASCCP algorithm booklet April 2013 for further guidelines.**

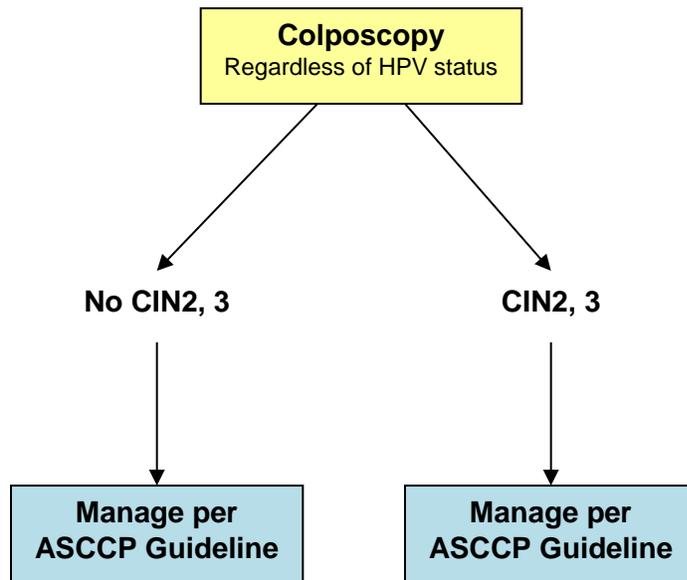
Initial Workup of Women with Atypical Glandular Cells (AGC)



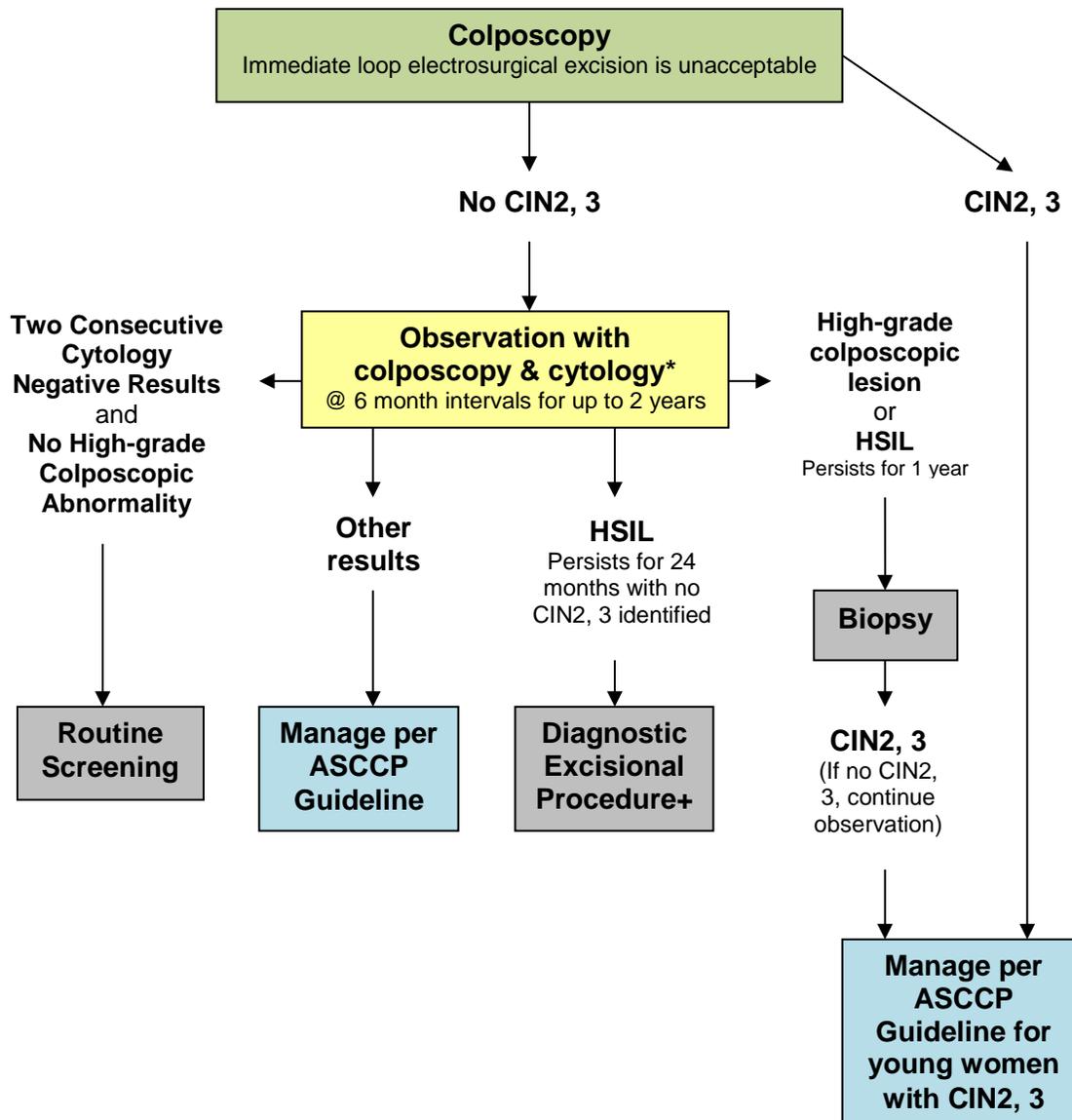
*Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

After colposcopy, management is directed by the colposcopist. Refer to the ASCCP algorithm booklet April 2013 for further guidelines.

**Management of Women with Atypical Squamous Cells:
Cannot Exclude High-grade SIL (ASC-H)
(For women between 21-24 years, see following algorithm.)**



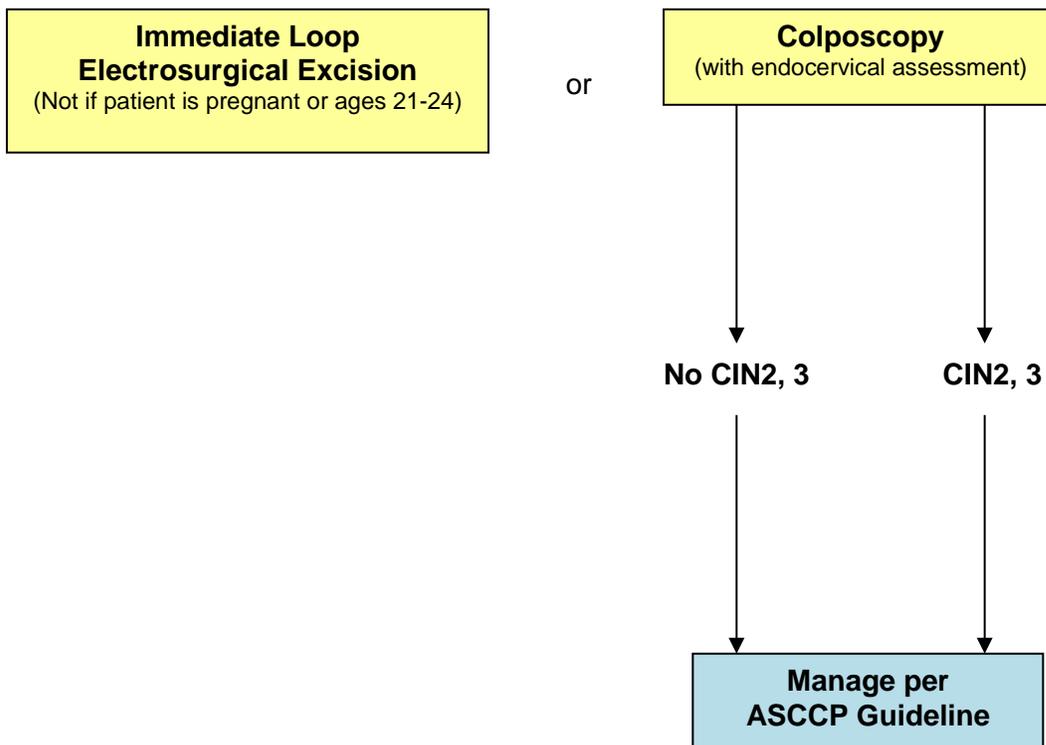
Management of Women Ages 21-24 years with Atypical Squamous Cells, Cannot Rule Out High-grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion



*If colposcopy is adequate and endocervical sampling is negative. Otherwise a diagnostic excisional procedure is indicated.

+Not if client is pregnant.

Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)



*Management options may vary if the woman is pregnant, postmenopausal, or ages 21-24.

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8. U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services*, January 2001.

CERUMEN, IMPACTED (EAR WAX)

SUBJECTIVE

- Ear feels plugged
- Diminished hearing
- Itching may be present
- History is negative for:
 - Ear drainage
 - Perforation of ear drum(s)
 - Ear pain
 - Ear surgery, e.g., “tubes”

OBJECTIVE

- Hardened and packed cerumen
- Tympanic membrane not visible

ASSESSMENT

- Impacted cerumen

PLAN

- Hearing assessment according to age
- Recommend softening ear wax with the following warmed to body temperature:
 - Use glycerin or mineral oil to fill each ear canal two or three times a day for 7 days or
 - recommend filling ear canal with Debrox daily for 3-4 days.

- Parent or guardian should be instructed in proper manipulation of ear lobe and cartilage to facilitate drops flowing into the ear

- Discourage the use of anything smaller than the finger tip for cleaning the ear canal, (i.e., Q-tips, bobby pins, toothpicks, match sticks, twigs or straw)

Referral Indicators:

- Earaches, ear pain
- Ear drainage
- Perforation of tympanic membrane
- Impacted cerumen that fails to respond to above management
- Impaired hearing or delayed and/or impaired speech
- Children less than 2 years of age
- Febrile

Follow-Up:

- Follow up as needed

Reference:

- <http://www.webmd.com/a-to-z-guides/ear-wax>

CONSTIPATION, ACUTE, CHILD

SUBJECTIVE

Malaise, abdominal cramping
History of hard, dry, stools
Possible history of involuntary fecal soiling in a previously toilet trained or older child
History of infrequent passage of stools relative to the individual's usual habit
Pain and/or straining at defecation; reluctance to sit on toilet
Stool streaked with blood
Diet and medication history

OBJECTIVE

Signs of dehydration
Anal fissure or evidence of irritation
Abdominal distention with or without palpable firm mass
Stool streaked with bright blood
Visible hemorrhoid

ASSESSMENT

Acute childhood constipation

PLAN

- Encourage defecation when urge presents
- Adjust diet to allow for adequate fluid and carbohydrate intake
- For infants 1 month and older: 1 ounce a day for every month of life up to about 4 months (a 3-month-old baby would get 3 ounces) of apple or pear juice; or use 1 to 2 tablespoons per day of dark corn syrup
- Once your infant is taking solids you can try vegetables and fruits, especially prunes.
- Older infants - increase fluid intake; increase amounts of pureed fruits in the diet, especially prunes and plums; the amount needed will vary with individual infants
- Older children - Increase fluid intake; add prunes, apricots, and figs to the daily diet; include high-residue substances such as bran, whole wheat, oatmeal, and green leafy vegetables in daily diet
- If these dietary changes don't help, call the PCP
- Discourage use of suppositories, laxatives, or enemas unless specifically ordered by health department physician or APN.
- For minor anal irritation, advise warm sitz baths and use of petroleum jelly or ointment and/or hypoallergenic moist wipes
- For previously toilet trained child, support for feet when toileting

NOTE: DO NOT GIVE HONEY TO CHILDREN LESS THAN ONE YEAR OLD DUE TO DANGER OF BOTULISM

Referral Indicators:

- Persistent, severe, or recurrent abdominal pain
- Persistent fecal soiling
- Persistent constipation
- Vomiting, dehydration, fever
- Breakdown of skin around anus
- Blood streaked stool

Follow-Up:

Patient/parent will be asked to contact health provider if not resolved in 24-48 hours

Reference

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006

DIAPER DERMATITIS (DIAPER RASH)

SUBJECTIVE

Caretaker reports diaper rash
Irritability

OBJECTIVE

Contact or irritant dermatitis: Chafed, reddened, non-raised areas over genital and buttocks area

Infected dermatitis: Inflamed, bright red, indurated and tender skin; With satellite lesions; thick white plaques with an erythematous base may be present on oral mucus membrane (thrush), especially during or following antibiotic therapy (see oral candidiasis/moniliasis)

ASSESSMENT

Contact or Infected Diaper Dermatitis

PLAN

For Contact Diaper Dermatitis:

- Change diaper as soon as possible after it becomes wet or soiled;
- Clean diaper area with warm water and a hypoallergenic/or unscented soap after each bowel movement; dry gently but thoroughly after each diaper change
- Leave diaper off during nap time to allow drying of the area
- A layer of protective diaper ointment/cream or a corn starch based powder may be applied to skin with each diaper change.
- Do not overdress infant
- Discourage use of waterproof pants, plastic covered diapers, tightly pinned or double diapers, scented diapers, and scented diaper wipes as many contain perfume or alcohol
- DO NOT USE TALCUM POWDER, BAKING SODA, OIL, OR PETROLEUM JELLY
- Provide laundry instructions for cloth diapers, if applicable:
Suggest laundering diapers in mild hypoallergenic detergent and rinse thoroughly
Use only hypoallergenic fabric softener

Referral Indicators:

Infected diaper dermatitis
Suspicion of burn
No response to treatment within 2-3 days
Presence of systemic involvement (e.g., fever)

Follow up:

Parent will be asked to contact health provider in 24-48 hours if not improved

Reference:

Mayo Clinic, Guide To Self-Care, Fifth Edition 2006
American Academy of Pediatrics, Healthy Children
<http://www.healthychildren.org/English/ages-stages/baby/diapers-clothing/Pages/Diaper-Rash-Solution.aspx>

FLUORIDE DEFICIENCY

NOTE:

- The use of dietary fluoride supplements is one alternative means of providing fluoride protection to the teeth of children 6 months old to 16 years of age who consume fluoride-deficient water with 0.6 ppm fluoride or less.
- Dietary fluoride supplements, in the form of daily tablets, lozenges, liquids, or vitamin-fluoride combinations, provide systemic benefits to developing teeth as well as topical benefits to erupted teeth. When practical, supplements should be prescribed as chewable tablets or lozenges to maximize the topical effects of fluoride.
- When prescribed and used appropriately, fluoride supplements provide benefits similar to those obtained from ingesting optimally-fluoride water over the same period of time.
- **When improperly prescribed, fluoride supplements may cause mild enamel fluorosis (white spots on teeth). Therefore, systemic fluoride supplements should never be prescribed to children in fluoridated communities who are already receiving optimally fluoridated water (0.7 ppm fluoride).**
- Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion in excess of that necessary to prevent tooth decay, a conservative approach to fluoride supplementation should be used and in accordance with the recently revised guidelines.
- If a child's primary drinking water source is a well, spring, or non-fluoridated community water system, a water sample must first be taken and analyzed to determine its fluoride content and what dosage of fluoride supplement, if any, is needed.

SUBJECTIVE

No other systemic source of fluoride besides that present in foods and beverages processed with fluoridated water
 Request for dietary fluoride supplement
 Age 6 months to 16 years

OBJECTIVE

Private community water supply with a fluoride content 0.6 ppm fluoride or below as confirmed by fluoride assay
 Dental caries are more common in areas of fluoride deficient water supply.

ASSESSMENT

Fluoride Deficiency

PLAN

Drinking water should be analyzed for fluoride content prior to supplementation in order to determine if supplements are necessary and how much to prescribe.

To determine the level of fluoride in the child's existing water supply:

1. Obtain water sample bottles from either Fluoridation Specialist (TDEC Nashville Env. Field Office, Division of Water Supply, 711 R.S. Gass Blvd, Nashville, TN 37216, Telephone 615-687-7037 or the Regional Dental Director.
2. Provide parent or guardian with 1 water sample bottle, request slip for fluoride determination.
3. Instruct patient on the correct procedure for collecting and handling of the water sample:
 - a. Using a kitchen or bathroom faucet allow cold water to run for at least 30 seconds.
 - b. Rinse out the sample bottle twice before filling.
 - c. Fill sample bottle with cold water and screw on cap firmly.
 - d. Mail the sample within 3 days.

Estimate an effective fluoride concentration as indicated (child is consuming water from multiple sources)

Example: If the home water supply is tested and the fluoride concentration is 0.2 ppm, but it only accounts for half of the child's daily water intake ($0.2 \text{ ppm} \times 0.50 = 0.1 \text{ ppm}$) and the day-care water supply has a known fluoride concentration of 1.0 ppm and it accounts for the remaining half of the child's daily intake ($1.0 \text{ ppm} \times 0.50 \text{ ppm}$) a dietary fluoride supplement (if prescribed) should be based on the effective fluoride concentration of 0.6 ppm and not 0.2 Ppm

Issue fluoride supplements according to the following dosage schedule:

Dietary Supplemental Fluoride Dosage Schedule in mg F/day
Revised, ADA Winter 1994

Age of Child	ppm fluoride in water supply		
	0-0.3 ppm	0.3-0.6 ppm	>0.6 ppm
Birth to 6 mo	0	0	0
6 mo to 3 yrs	0.25 mg	0	0
3 to 6 yrs	0.5mg	0.25mg	0
6-16 yrs	1.0mg	0.5mg	0

Issue on a "one bottle at a time" basis

Each bottle should not exceed the recommended limit of 120 mgs of fluoride

Health Teaching:

There is a well-documented decline in dental caries in children in the United States which is due to widespread use of various forms of fluoride

Even people living in communities where water supplies are not fluoridated still benefit from exposure to fluorides found in toothpaste, mouth rinses, professionally applied fluorides and in foods processed in cities where water supplies are fluoridated (i.e., the “halo” phenomenon)

In order to reduce risk of dental fluorosis, it is recommended that parents closely supervise tooth brushing by young children to prevent their ingestion of fluoride toothpaste and to ensure that only very small quantities (pea-sized amounts) are used

Careful use of fluoride is particularly appropriate during the time of anterior tooth enamel development (birth to 8 years)

Follow-Up:

The parent or guardian of the child will be asked to return for a refill when one bottle is near completion or if the fluoride status of the water supply changes

Reference

MMWR August 17, 2001 / 50 (RR14) 1-42

MMWR “Achievements....etc.” October 22, 1999 / 48 (41); 933-940

Hagan JF, Shaw JS, Duncan PM, eds. 2008 *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third edition. Elk Grove Village, IL: American Academy of Pediatrics.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

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.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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AGE ¹	INFANCY								EARLY CHILDHOOD						MIDDLE CHILDHOOD						ADOLESCENCE														
	Prenatal ²	Newborn ³	3-5 d ⁴	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y			
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
MEASUREMENTS																																			
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Head Circumference		●	●	●	●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●	●	●	●	●																				
Body Mass Index ⁵												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
Blood Pressure ⁶		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
SENSORY SCREENING																																			
Vision ⁷		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★	★	★	
Hearing		● ⁸	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★	★	
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																			
Developmental Screening ⁹								●				●	●	●	●																				
Autism Screening ¹⁰											●	●	●	●	●																				
Developmental Surveillance		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment ¹¹																						★	★	★	★	★	★	★	★	★	★	★	★	★	★
Depression Screening ¹²																						●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION¹³		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES¹⁴																																			
Newborn Blood Screening ¹⁵		←	●	→																															
Critical Congenital Heart Defect Screening ¹⁶		●																																	
Immunization ¹⁷		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin ¹⁸					★				●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening ¹⁹						★	★	● or ★ ²⁰	●	★	● or ★ ²⁰	●	★	★	★	★	★																		
Tuberculosis Testing ²¹				★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	
Dyslipidemia Screening ²²												★		★		★	★		★	←	●	→	★	★	★	★	★	★	★	★	★	★	★	★	
STI/HIV Screening ²³																						★	★	★	★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening ²⁴																																			●
ORAL HEALTH²⁵						★	★	● or ★	● or ★	● or ★	● or ★	● or ★	●	●	●	●	●																		
Fluoride Varnish ²⁶							←	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

- If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (<http://pediatrics.aappublications.org/content/124/4/1227.full>).
- Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
- Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (<http://pediatrics.aappublications.org/content/129/3/e827.full>). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (<http://pediatrics.aappublications.org/content/125/2/405.full>).
- Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
- Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
- A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (<http://pediatrics.aappublications.org/content/137/1/1.51>) and "Procedures for Evaluation of the Visual System by Pediatricians" (<http://pediatrics.aappublications.org/content/137/1/1.52>).
- All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (<http://pediatrics.aappublications.org/content/120/4/898.full>).
- See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (<http://pediatrics.aappublications.org/content/118/1/405.full>).
- Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (<http://pediatrics.aappublications.org/content/120/5/1183.full>).

- A recommended screening tool is available at <http://www.ceasar-boston.org/CRAFFT/index.php>.
- Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
- At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (<http://pediatrics.aappublications.org/content/127/5/991.full>).
- These may be modified, depending on entry point into schedule and individual need.
- The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uhscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
- Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (<http://pediatrics.aappublications.org/content/129/1/190.full>).
- Schedules, per the AAP Committee on Infectious Diseases, are available at: <http://aapredbook.aappublications.org/site/resources/zschedules.xhtml>. Every visit should be an opportunity to update and complete a child's immunizations.
- See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (<http://pediatrics.aappublications.org/content/126/5/1040.full>).
- For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
- Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.

- Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
- See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (<http://pediatrics.aappublications.org/content/128/5/1023.full>) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
- See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspstf.htm>). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (<http://pediatrics.aappublications.org/content/126/3/583.full>).
- Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (<http://pediatrics.aappublications.org/content/111/5/1113.full>), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (<http://pediatrics.aappublications.org/content/134/6/1224.full>).
- See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspstf.htm>). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>).

Summary of changes made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This Schedule reflects changes approved in October 2015 and published in January 2016. For updates, visit www.aap.org/periodicityschedule.

Changes made October 2015

- **Vision Screening-** The routine screening at age 18 has been changed to a risk assessment.
- Footnote 7 has been updated to read, “A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians (<http://pediatrics.aappublications.org/content/137/1/1.51>) and “Procedures for Evaluation of the Visual System by Pediatricians” (<http://pediatrics.aappublications.org/content/137/1/1.52>).

Changes made May 2015

- **Oral Health-** A subheading has been added for fluoride varnish, with a recommendation from 6 months through 5 years.
- Footnote 25 wording has been edited and also includes reference to the 2014 clinical report, “Fluoride Use in Caries Prevention in the Primary Care Setting” (<http://pediatrics.aappublications.org/content/134/3/626>) and 2014 policy statement, “Maintaining and Improving the Oral Health of Young Children” (<http://pediatrics.aappublications.org/content/134/6/1224.full>).
- Footnote 26 has been added to the new fluoride varnish subheading: See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm>). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” (<http://pediatrics.aappublications.org/content/134/3/626>).

Changes made March 2014

Changes to Developmental/Behavioral Assessment

- **Alcohol and Drug Use Assessment-** Information regarding a recommended screening tool (CRAFFT) was added.
- **Depression-** Screening for depression at ages 11 through 21 has been added, along with suggested screening tools.

Changes to Procedures

- **Dyslipidemia screening-** An additional screening between 9 and 11 years of age has been added. The reference has been updated to the AAP-endorsed National Heart Blood and Lung Institute policy (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
- **Hematocrit or hemoglobin-** A risk assessment has been added at 15 and 30 months. The reference has been updated to the current AAP policy (<http://pediatrics.aappublications.org/content/126/5/1040.full>).
- **STI/HIV screening-** A screen for HIV has been added between 16 and 18 years. Information on screening adolescents for HIV has been added in the footnotes. STI screening now references recommendations made in the AAP Red Book. This category was previously titled “STI Screening.”
- **Cervical dysplasia-** Adolescents should no longer be routinely screened for cervical dysplasia until age 21. Indications for pelvic exams prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (<http://pediatrics.aappublications.org/content/126/3/583.full>).
- **Critical Congenital Heart Disease-** Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement, “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (<http://pediatrics.aappublications.org/content/129/1/190.full>).

See www.aap.org/periodicityschedule for additional updates made to footnotes and references in March 2014.

ROTAVIRUS VACCINE **(RotaTeq[®] “RV5” by Merck, Rotarix[®] “RV1” by GSK)**

GENERAL INFORMATION

Rotavirus causes severe diarrhea and is usually accompanied by fever and vomiting. It is the most common cause of severe gastroenteritis in infants and young children in the U.S. Rotavirus is seasonal, with peak numbers of cases occurring in the winter and early spring. Before the introduction of vaccine in 2006, rotavirus diarrhea resulted in about 200,000 emergency room visits and 55,000 hospitalizations in the US annually. Transmission occurs through the fecal-oral route.

Rotavirus vaccines are live vaccines administered by mouth, between the age of 6 weeks zero days and 8 months zero days of age. They may be administered simultaneously with other vaccines. Two rotavirus vaccines are licensed in the U.S.: Rotateq[®] by Merck (abbreviated “RV5” by CDC) and Rotarix[®] by GSK (abbreviated “RV1” by CDC). RV5(Rotateq) is a three-dose series and RV1 (Rotarix) is a two-dose series: the ACIP/CDC expresses no preference between the two vaccines. Please note: this protocol follows ACIP/CDC recommendations for a harmonized schedule of the two brands, which differs from product package inserts.

Special situations:

Infants in contact with pregnant women or persons with compromised immune systems **may** be vaccinated.

Infants who have received or will receive blood or antibody-containing products may receive the vaccine *at any time*. Previously, it was recommended that such infants wait 42 days before vaccination.

Re-administration of a dose to an infant who spits up or vomits during or after administration of the vaccine is not generally recommended. If this occurs, continue series at normal interval.

If *any* dose in the series is RV5, or if the brand of any dose is unknown, a total of 3 doses must be administered to complete the series. Although preferable to use one brand for the entire series, vaccination should not be deferred because the product previously used is unknown or unavailable.

3-Dose Immunization Schedule: If any dose is Rotateq® (RV5) or unknown brand

Dose	Product	Recommended age	Minimum interval to next dose	Special Notes
Dose 1	RotaTeq (RV5) or Rotarix (RV1)	2 months: Administer between age 6 weeks and 14 weeks 6 days (42-104 days)	4 weeks	If dose 1 was given at ≥ 15 weeks, the series may be continued
Dose 2	RotaTeq (RV5) or Rotarix (RV1)	4 months	4 weeks	
Dose 3 Final dose	RotaTeq (RV5) or Rotarix (RV1)	6 months		Do not administer after age 8 months 0 days

2-Dose Immunization Schedule: If Using Rotarix® (RV1) Only

Dose Number	Recommended age at administration	Minimum interval to next dose	Special Notes
Dose 1	2 months: Administer between age 6 weeks and 14 weeks 6 days (42-104 days)	4 weeks	If dose 1 was given at ≥ 15 weeks, the series should be completed
Dose 2 Final dose	4 months		Do not administer after 8 months 0 days of age.

Contraindications to giving the vaccine include the following:

- Infants <6 weeks (42 days) or >8 months 0 days (precise age in days not specified)
- Infants with a history of severe allergic reaction to a prior dose of rotavirus vaccine or to any rotavirus vaccine component
- Infants with a severe (anaphylactic) reaction to latex should not receive Rotarix (RV1). RotaTeq (RV5) should be used because it is latex free.
- Previous history of intussusception
- Infants diagnosed with Severe Combined Immunodeficiency (SCID). Screening for SCID was added to Tennessee's Newborn Screening Program effective January 1, 2016.

Precautions (risks and benefits of vaccination should be carefully evaluated under the following circumstances):

- Moderate to severe acute illness (defer until illness resolves) [Note: Low grade fever <100.5°F or mild upper respiratory infections are not reasons for deferring]
- Preexisting chronic gastrointestinal disease (e.g., chronic diarrhea, congenital abdominal disorders)
- Altered immunocompetence including:
 - Blood disorders or cancers involving the bone marrow or lymph system
 - Infants on high dose systemic corticosteroids
 - Infants with an immunodeficiency other than SCID

Adverse Reactions:

Severe allergic reaction to vaccine (rare)
High fever

PLAN

- Ask parent/guardian about contraindications, precautions
- Have parent/guardian read Vaccine Information Statement
- If using Rotarix (RV1), reconstitute vaccine according to manufacturer's instructions
- Administer the vaccine by mouth according to the manufacturer instructions [if an incomplete dose is administered or the infant vomits, repeating the dose is not recommended]
- Counsel regarding side effects of vaccine
- Advise parent/guardian to return for the next dose in a minimum of 4 weeks
- Advise to wait in clinic for 20 minutes after administration of vaccine
- Record manufacturer and lot number of the vaccine administered, date vaccine and VIS given, address of facility, and name and title of person administering vaccine
- Instruct patient/guardian to contact Health Department if adverse reaction occurs (complete VAERS)

Referral Indicators:

Infants with precautions to vaccination other than an acute moderate to severe illness should be referred for a health department physician order.

REFERENCES

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