



Information for You from Your Health Care Team

Back to Basics

Good personal hygiene can make you healthier and less likely to get sick. It also helps you to look good and feel good. Read this handout to be sure you are covering the basics of personal care. Talk with your nurse if you have questions specific about your needs.

Wash Your Hands Often

- Handwashing is the best way to prevent infections and the spread of diseases.
- Always wash your hands before you eat, before you handle food, and after you use the toilet.
- Wash your hands often if you are sick or around people who are sick.
- Use a lot of soap and water to work up a good lather.



Keep Your Body Clean and Healthy

- Take a shower or tub bath at least two to three times a week.
- Use soap and water. Rinse well. Dry completely.
- Shampoo your hair every time you bathe.
- Clean your genitals and armpits every day.
- Keep feet clean and dry. Wear clean socks. Don't walk barefoot outside.
- Use body lotion to keep skin soft.
- Women should always wipe from front to back after using the toilet.



Take Care of Your Teeth

- Brush your teeth after every morning and night. Try to brush after every meal.
- Floss between each tooth every day.
- See your dentist at least every 6 months.



Take Care of Your Nails

- Clean underneath nails every day.
- Keep fingernails short. They should be cut to be just longer than your fingertips.
- Cut toenails straight across, just longer than your toe.
- If you are unable to care for your nails, ask for help.
- If you have diabetes or decreased blood flow to your legs, ask your health care provider about proper care.



Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB	see footnote 1	HepB	HepB	HepB					
Rotavirus ²			Rota	Rota	Rota							
Diphtheria, Tetanus, Pertussis ³			DTaP	DTaP	DTaP	see footnote 3	DTaP					DTaP
Haemophilus influenzae type b ⁴			Hib	Hib	Hib ⁴	Hib						
Pneumococcal ⁵			PCV	PCV	PCV	PCV					PPV	
Inactivated Poliovirus			IPV	IPV		IPV						IPV
Influenza ⁶							Influenza (Yearly)					
Measles, Mumps, Rubella ⁷							MMR					MMR
Varicella ⁸							Varicella					Varicella
Hepatitis A ⁹							HepA (2 doses)				HepA Series	
Meningococcal ¹⁰												MCV4

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not

contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high risk conditions: <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can be delayed, in rare cases, with a provider's order and a copy of the mother's negative HBsAg laboratory report in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered no earlier than age 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Administer the first dose at age 6–12 weeks.
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer any dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHibit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children age 12 months or older.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])

- Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
- Administer PPV to children aged 2 years and older with underlying medical conditions.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- Administer annually to children aged 6–59 months and to all close contacts of children aged 0–59 months.
- Administer annually to children 5 years of age and older with certain risk factors, to other persons (including household members) in close contact with persons in groups at higher risk, and to any child whose parents request vaccination.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if age 6–35 mos or 0.5 mL if age 3 years or older.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season, but only received one dose.

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided 4 weeks or more have elapsed since the first dose.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer second dose at age 4–6 years; may be administered 3 months or more after first dose.
- Don't repeat second dose if administered 28 days or more after first dose.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for all children aged 1 yr (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

10. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])

- MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. Use of MPSV4 is also acceptable.
- Persons who received MPSV4 3 or more years prior and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Information for You from Your Health Care Team

Temperature Conversion Chart

There are 2 scales used for taking temperature; Fahrenheit (F) and Centigrade (C). In order for you to know what your child's temperature is, you will need to be able to change from the Fahrenheit to the Centigrade scale. You can use the chart below to find the Fahrenheit temperature for each Centigrade temperature. To read the chart, find the reading from your thermometer on the chart and look at the number directly across from it. For example, a temperature of 37.0° C is the same as 98.6° F (see*).

°C	°F	°C	°F	°C	°F	°C	°F
35.0	95.0	36.7	98.0	38.3	101.0	40.0	104.0
35.1	95.2	36.8	98.2	38.4	101.2	40.1	104.2
35.2	95.4	36.9	98.4	38.6	101.4	40.2	104.4
35.3	95.6	37.0*	98.6	38.7	101.6	40.3	104.6
35.4	95.8	37.1	98.8	38.8	101.8	40.4	104.8
35.6	96.0	37.2	99.0	38.9	102.0	40.6	105.0
35.7	96.2	37.3	99.2	39.0	102.2	40.7	105.2
35.8	96.4	37.4	99.4	39.1	102.4	40.8	105.4
35.9	96.6	37.6	99.6	39.2	102.6	40.9	105.6
36.0	96.8	37.7	99.8	39.3	102.8	41.0	105.8
36.1	97.0	37.8	100.0	39.4	103.0	41.1	106.0
36.2	97.2	37.9	100.2	39.6	103.2	41.2	106.2
36.3	97.4	38.0	100.4	39.7	103.4	41.3	106.4
36.4	97.6	38.1	100.6	39.8	103.6	41.4	106.6
36.6	97.8	38.2	100.8	39.9	103.8	41.6	106.8



Information for You from Your Health Care Team

Oximeter

What is an Oximeter?

An oximeter is a small machine that measures oxygen saturation (the amount of oxygen) in you child's blood.

To get this measurement, a small sensor (like a band-aid) is taped onto your child's finger or toe. When the oximeter is on, a small red light can be seen in the sensor. The sensor is painless and the red light does not get hot.

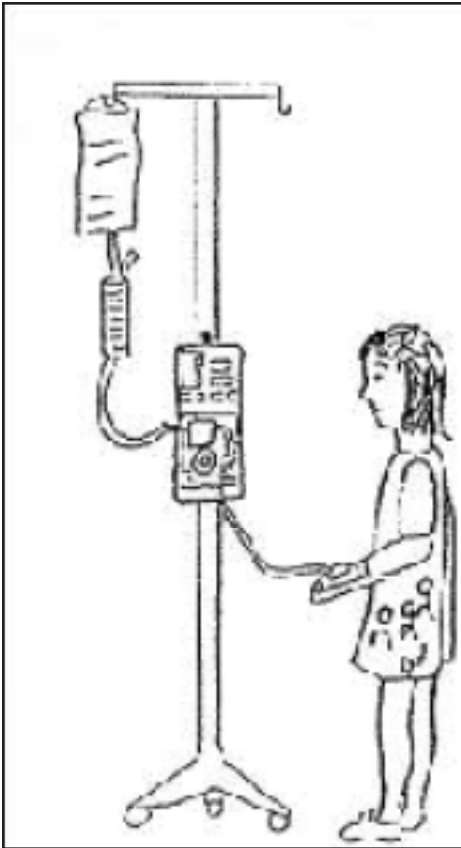
Why are Oximeters used?

There are many reasons to use an oximeter. It helps show how well your child is breathing and if extra oxygen is needed. If your child is on oxygen, it will help the doctors decide how much oxygen to give.



Information for You from Your Health Care Team

Having an “IV”



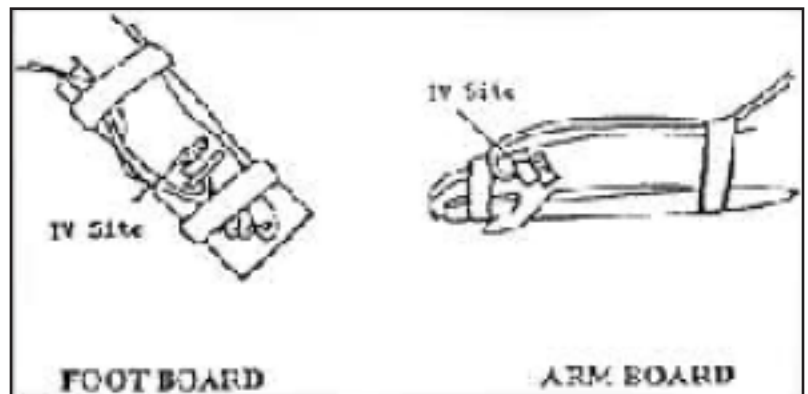
What is an “IV”

“IV” stands for “intravenous,” which means inside the vein.

Fluids and medicines are often given into the veins through a small needle or catheter (a hollow plastic tube). The IV Needle is joined by tubing to a bag of medicine, fluid, or blood. The tubing may also be attached to a special machine that pumps the fluid into the vein.

Infants often have IVs put in the hand, arm, foot, and scalp.

Children and teens often have IVs in the hand or arm. The nurse will decide the best place for your child. After the IV has been put in the vein, your child’s nurse will tape it to help keep it in place.



Keeping your child’s arm or foot still may help the IV stay in place. Your child’s hand or foot may be kept still by putting it on a padded board and taping it in place. Sometimes infants and small children may need their other arm or foot placed in a safety device to keep them from pulling the IV out.

Why have an “IV”?

- Some medications can only be given by IV.
- Some medications do not work well when given by mouth.
- Sometimes an IV can be used instead of shots.
- When your child cannot eat or drink because of a certain test, surgery, or if your child’s stomach is upset, an IV is often the only way to give medications and fluids.

How is the “IV” put into the vein?

- When your child’s doctor decides that an IV is needed, the nurse will put the IV in place. The child is often taken to the treatment room for this. Other staff members may also be there to help hold and comfort your child.

- Once the IV site is chosen, your child's skin will be cleaned with alcohol. When the skin is first punctured, it will hurt a little. There should be little or no pain after the needle is in the vein.
- After your child's nurse is sure that the IV is in the vein, he/she will tape it in place.

Taking care of your child's "IV":

- The place where the needle goes through the skin will be checked often by your child's nurse.
- Sometimes IV's slip out of the vein and the fluid may make the skin puffy and red. If this happens, call your nurse right away. A new vein may be needed if the site is red or puffy or after the needle has been in place for two or three days.
- Your child's doctor will decide how long the IV is needed.
- When the IV is no longer necessary, it can be easily removed.

Remember, call your child's nurse if:

- You child cries and you cannot comfort him/her.
- Your child complains of pain where the IV goes through the skin.
- The IV site is red or puffy.
- The IV pump alarms.



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Helping Your Child with Pain Control

Pain is an uncomfortable feeling that tells you something may be wrong in your body. When there is an injury to your body, such as through surgery, nerve cells send signals into the spinal cord and then up to the brain.

Pain medicine blocks those signals or reduces their effect on the brain. After your child's surgery or treatment, your nurses and doctors will ask you and your child about the pain because they want your child to be comfortable. Both medicine and non-medicine treatments can help to prevent and control pain. This information will help you take an active role in making sure that your child's pain is minimal. Being prepared helps put you and your child in control!

Ask Your Doctor or Nurse What to Expect

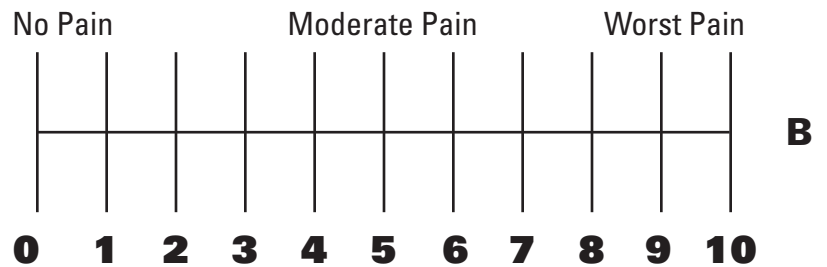
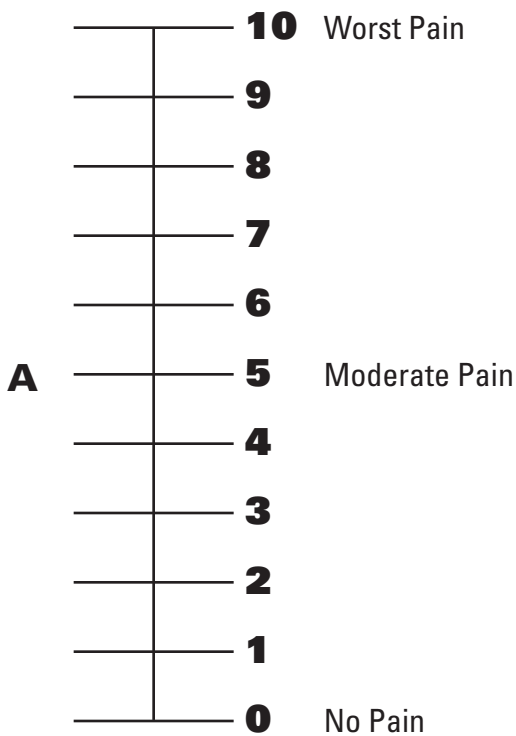
- Will there be much pain after the surgery or treatment?
- Where will the pain be?
- How long is the pain likely to last?

Discuss Pain Control Options With Your Doctor or Nurse

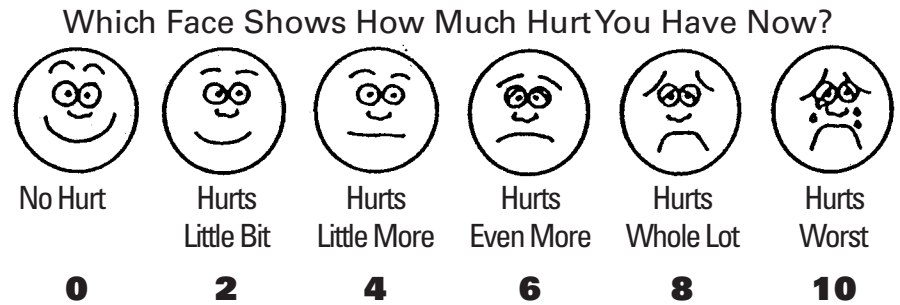
- How will pain be controlled after surgery or treatment?
- Tell the doctor or nurse what has worked for your child in the past and what has not worked in the past.
- Ask about possible side effects that may occur with pain medicine.
- Tell the doctor or nurse about your concern
- Ask your nurse about non-medicine options to decrease your child's pain. These include rocking and holding your child; hot or cold packs; music, stories, or videos to distract your child; and techniques to help your child relax.

Help the Doctors and Nurses Measure the Pain

- They may ask your child to rate the pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain they can imagine; or to choose a face from the Faces Scale that best describes the pain. Your child may also choose to draw his or her own rating scale to describe pain. You may need to help your child with these ratings.
- It may be helpful to have your child set a pain control goal, such as having no pain greater than a "2" on the scale. For children who are not able to use the pain scales, the doctors and nurses will rely on other signals of pain, such as increased heart rate, crying or grimacing, and on your judgment of your child's level of pain to guide their pain relief efforts.
- Tell your doctor or nurse about any pain that won't go away.
- Stick with the pain control plan if it is working. If it isn't working, your doctors and nurses can change the plan.



May be duplicated for re in clinical practice. From McCaffery M, Pasero C: *Pain: Clinical manual* p. 63. Copyright © 1999 Mosby, Inc.
Figure 3.2 - The vertical version (A) of the numerical rating scale may be more easily understood than the horizontal version (B).



Modified from Wong DL: *Whaley & Wong's Essentials in Pediatric Nursing*, ed. 5, pp.1215-1216, St. Louis, 1997, Mosby

Things You Should Know

- Something should be done about the pain as soon as it starts. It is more difficult to ease pain once it has become established. This is a key step in proper pain control.
- The nurses may ask your child to accept pain medicine at set times for the first 24 hours after surgery. Our goal is to prevent or minimize pain.
- Pain medication, can be given by mouth, into the bloodstream (intravenous or IV), in the rectum, or in the muscle (shot). The nurses will try to avoid giving pain medicine in the muscle to avoid further discomfort.
- If you know your child's pain will get worse when he or she starts walking or doing breathing treatments, ask for pain medicine first.

Speak up if you have any questions or concerns