**Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance**

**GUIDE I: 0–1 mo (Ontario)**

**NAME: ____________________  Birth Day (d/m/yy): ___________  M | F | **

Gestational Age: ___________  Birth Length: ___________ cm  Birth Weight: ___________ g

**DATE OF VISIT ________/________/20______**

**PARENT/CAREGIVER CONCERNS**

**DATE OF VISIT ________/________/20______**

**DATE OF VISIT ________/________/20______**

GROWTH use WHO growth charts. Correct age until 24–36 months if < 37 weeks gestation

<table>
<thead>
<tr>
<th>Length</th>
<th>Weight</th>
<th>HC (avg 35 cm)</th>
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**NUTRITION** For each item discussed, indicate “✓” for no concerns, or “✗” if concerns

- Breastfeeding (exclusive)
  - Vitamin D 400 IU/day
  - Formula Feeding (iron-fortified)/preparation
  - Stool pattern and urine output
  - Supplementation: water or other fluids

**EDUCATION AND ADVICE** Repeat discussion of items is based on perceived risk or need

- Injury Prevention
  - Motorized vehicles/Car seat
  - Carbon monoxide/Smoke detectors
  - Firearm safety
  - Hot water <49°C/Bath safety
  - Choking/Safe toys
  - Pacifier use
  - Safe sleep (position, room sharing, avoid bed sharing)
  - Falls (stairs, change table)

- Behaviour and Family Issues
  - Crying
  - Healthy sleep habits
  - Night waking
  - Soothability/Responsiveness
  - Parenting/Bonding
  - Family conflict/Stress
  - Siblings
  - Parental fatigue/Postpartum depression
  - High risk infants/Assess home visit need
  - Inquire re difficulty making ends meet or feeding your family
  - Falls well on nipple
  - No parent/caregiver concerns

- Physical Examination
  - Skin (jaundice, bruising)
  - Ears (TMs) Hearing inquiry/screening
  - Tongue mobility
  - Heart/Lungs
  - Umbilicus
  - Testicles/Genitalia
  - Patency of anus
  - Muscle tone
  - Skin (jaundice, bruising)
  - Ears (TMs) Hearing inquiry/screening
  - Tongue mobility
  - Heart/Lungs
  - Umbilicus
  - Testicles/Genitalia
  - Muscle tone

- Problems and Plans/Current & New Referrals
  - E.g. medical specialist, dietitian, speech, audiology, PT, OT, eyes, dental, social-determinants resources

- Investigations/Screening and Immunization
  - Discuss immunization pain reduction strategies
  - Record Vaccines on Guide V

- If HBsAg-positive parent/sibling Hep B vaccine #2

**Physical support has been provided by the Government of Ontario.**

**For fair use authorization, see www.rourkebabyrecord.ca**

Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the Rourke Baby Record is meant to be used as a guide only.
Rourke Baby Record: Evidence-Based Infant (Child Health Maintenance)  
GUIDE II: 2–6 mos  
(Ontario) 

NAME: ___________________________ Birth Day (d/m/y): __________________ M | F | ________/________/20_____

Gestational Age: ________ Birth Length: ________ cm Birth Wt: ________ g Birth Head Circ: ________ cm

DATE OF VISIT ________/________/20_____

DATE OF VISIT ________/________/20_____

DATE OF VISIT ________/________/20_____

2 months  
4 months  
6 months

GROWTH1 use WHO growth charts. Correct age until 24–36 months if < 37 weeks gestation.

<table>
<thead>
<tr>
<th>Length</th>
<th>Weight</th>
<th>Head circ.</th>
<th>Length</th>
<th>Weight</th>
<th>Head Circ.</th>
<th>Length</th>
<th>Weight (x2 BW)</th>
<th>Head Circ.</th>
</tr>
</thead>
</table>

PARENT/CAREGIVER CONCERNS

NUTRITION1 For each item discussed, indicate “✓” for no concerns, or “✗” if concerns.

Breastfeeding (exclusive)1  
Breastfeeding1 – introduction of solids1  
Vitamin D 400 IU/day1  
Formula Feeding (iron-fortified/preparation)1  
Formula Feeding – iron-fortified/preparation1  
Discuss future introduction of solids1  
Food intake (x2 BW)1  
Iron containing foods1  
Avoid juices/sweetened liquids1  
No bottles in bed

INVESTIGATIONS/SCREENING2 AND IMMUNIZATION3 Discuss immunization pain reduction strategies3 Record Vaccines on Guide V

STRENGTH OF RECOMMENDATION

Strength of recommendation is based on literature review using the classification: Good (bold type); Fair (italic type); Inconclusive evidence/Consensus (plain type). See literature review table at www.rourkebabyrecord.ca

PROBLEMS AND PLANS/CURRENT & NEW REFERRALS4 E.g. medical specialist, dietitian, speech, audiology, PT, OT, eyes, dental, social-determinants resources

SIGNATURE
Family history:
- Parental fatigue/Stress/Discipline/Parenting skills programs
- Healthy sleep habits
- Walks up/down stairs
- Skim, 1% or 2% milk (~ 500 mLs/16 oz) /day
- No parent/caregiver concerns
- Turns/Responds when name is called
- Turns pages one at a time
- No bottles
- Second-hand smoke
- Hearing inquiry
- Uses toys for pretend play (e.g.,
- Anterior fontanelle closed
- Bath safety
- Shares some of the time
- Tries to comfort someone who
- Motorized vehicles/Car seat (child/booster)
- No parent/caregiver concerns
- Skim, 1% or 2% milk (~ 500 mLs/16 oz) /day
- Throws and catches a ball
- Tries to run
- Looks for toy when asked or pointed in direction
- Inquire re: vegetarian diets
- Homogenized milk [500–750 mLs (16–24 oz) /day
- 1
- Tonsil size/Sleep-disordered breathing
- Points to what he/she wants
- Removes hat/Socks without help
- 1
- 2
- 3
- Head Circ. (HC)
- Hemoglobin (If at risk)
- Weight
- Asks and answers lots of
- Retells the sequence of a story
- No parent/caregiver concerns
- Points to several different body parts
- Poisons
- 1
- 2
- 4
- Dental cleaning/Fluoride/Dentist
- Toilet learning
- No OTC cough/Cold medicine

Tasks are set after the time of normal milestone acquisition.

EDUCATION/ADVICE: Repeat discussion of items is based on perceived risk or need

NUTRITION: For each item discussed, indicate “V” for no concerns, or “X” if concerns

Injury Prevention
- Bike helmets
- Firearms safety
- Matches
- Poisons
- PCC#1

Behaviour
- Parent/child interaction
- Discipline/Parenting skills programs
- Healthy sleep habits
- Parental fatigue/Depression
- Family conflict/Stress
- Siblings

Family
- Healthy sleep habits
- Assess child care/Preschool needs/school readiness
- Socializing/Peer play opportunities
- Family healthy active living/Sedentary behaviour/Screen time
- Family healthy active living/sedentary behaviour/screen time

Environmental Health
- Second-hand smoke
- Sun exposure/Sunscreens/insect repellent
- Pesticide exposure

Other
- Toilet learning
- No OTC cough/Cold medicine

PROBLEMS AND PLANS/CURRENT & NEW REFERRALS
- E.g. medical specialist, dietitian, speech, audiology, PT, OT, eyes, dental, social-determinants resources

INVESTIGATIONS/SCREENING/IMMUNIZATION
- Discuss immunization pain reduction strategies
- Record Vaccines on Guide V

INVESTIGATIONS/SCREENING/IMMUNIZATION
- Record Vaccines on Guide V

SIGNATURE
Provincial guidelines vary and are available at the Public Health Agency of Canada (PHAC). Ontario Immunization Schedule

For additional information, refer to the National Advisory Committee on Immunization website.

NAME: ___________________________ Birth Day (d/m/yy): _____________________ M | F | |

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>NACI recommendations</th>
<th>Date given</th>
<th>Injection site</th>
<th>Lot number</th>
<th>Expiry date</th>
<th>Initials</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Rotavirus³</td>
<td>2 or 3 doses # doses varies with manufacturer</td>
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<tr>
<td>DTaP/IPV³</td>
<td>4 doses (2, 4, 6, 18 months)</td>
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<tr>
<td>Hib³</td>
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<tr>
<td>Pneumococcal Conjugate³</td>
<td>3 or 4 doses (2, 4, ±6, 12–15 months)</td>
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<tr>
<td>Men-Or-Conjugate³</td>
<td>MCV-C: 1 dose at 12 months</td>
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<td></td>
<td>MCV-C or MCV-Q: 1 dose at 12 years or during adolescence</td>
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<td></td>
<td>if at increased risk: - MCV-C: 3 doses at 2, 4 &amp; 12 months - MCV-Q: 2 or 3 doses at 2 years or older - 4MenB: at 2 months or older</td>
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<tr>
<td>Hepatitis B³</td>
<td>3 doses in infancy OR 2–3 doses preteen/teen</td>
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<td>Can be combined with Hep A vaccine</td>
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<td>MMR or MMR⁵</td>
<td>2 doses (12 months, 18 months OR 4 years)</td>
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<tr>
<td>Varicella³</td>
<td>2 doses (12 months–12 years – MMRV or univalent) OR 2 doses (&gt;13 years–univalent)</td>
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<tr>
<td>DTaP/IPV³</td>
<td>1 dose (4–6 years)</td>
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<tr>
<td>dTap³</td>
<td>1 dose (14–16 years)</td>
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<tr>
<td>Influenza³</td>
<td>1 dose annually (46–59 months and high risk &gt; 5 years) First yr only for &lt; 9 years – give 2 doses 1 month apart</td>
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<td>HPV</td>
<td>Starting at 9 years of age, as per provincial/territorial guidelines</td>
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<td>Other</td>
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³Resources 3: Immunization

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GROWTH
• Important: Corrected age should be used at least until 24 to 36 months of age for premature infants born <37 weeks gestation.
• Measuring growth: The growth of all term infants, both breastfed and non-breastfed, and preschoolers should be evaluated using the World Health Organization growth charts from the 2006 Health Organization Child Growth Standards (hereafter referred to as the "WHO Growth Charts"). These charts display measurements of length (birth to 2 years) or standing height (≥2 years), weight, head circumference (birth to 2 years) and calculation of BMI (2-5 years)
• WHO Growth Charts Adapted for Canada (ICG) Growth Monitoring (CFTPIC) Optimal growth monitoring (CPS)

NUTRITION: Nutrition for healthy term infants (NHTI): 0-6 months 6-24 months NutriSTEPrift
• Overview NHTI 0-6 months (CPS) Nutrition Guidelines D6 years (OSNPH) Dietitians of Canada
• Breastfeeding: Exclusive breastfeeding is recommended for the first six months of life for healthy term infants. Introduction of solids should be led by the infant’s signs of readiness:
  – a few weeks before to just after 6 months. Breast milk is the optimal food for infants, and breastfeeding (with complementary foods) may continue up to 2 years and beyond unless contraindicated. Breastfeeding reduces gastrointestinal and respiratory infections and helps protect against SIDS. Maternal support both antenatal and postpartum) increases breastfeeding and prolongs its duration. Early and frequent mother-infant contact, room in, and banning handouts of free infant formula increase breastfeeding rates.
  – Baby-Friendly Initiative (Breastfeeding Committee for Canada)
  – Apgar and breastfeeding (CPS)
• Maternal medications when breastfeeding: Drugs and Lactation Database (TORDNET)
• Vitamin D supplementation: 400 IU/day (800 IU/day in high-risk infants) is recommended for infants as they are being breastfed. Breastfeeding mothers should continue to take Vitamin D supplements for the duration of breastfeeding.
  – Vitamin D supplementation (CPS)
• Infant formula: Discourage the use of homemade infant formulas.
  – Formula composition and use Alberta Health Services
  – Summary Sheet
• Formula preparation and handling: Powdered formula reconstitution and handling (HC)
• Milk consumption range is consensus only & is provided as an approximate guide.
• Soy-based formula is not recommended for routine use in term infants as an equivalent alternative to cow’s milk formula, or for cow milk protein allergy, and is contraindicated for premature infants. Soy formula is not recommended for premature infants.
• Avoid all sweetened fruit drinks, sport-drinks, energy drinks and soft-drinks: restrict fruit juice consumption to a maximum of 1/2 cup (125 mL) per day.
• Colic: Dietary interventions for colic (CPS)
• Transferring to solid food: A few weeks before to just after 6 months, start iron containing foods to avoid iron deficiency. A variety of soft texture foods, ranging from purées to finger foods, can be introduced.
• Allergenic foods: Delaying the introduction of priority food allergens is not currently recommended to prevent food allergies, including for infants at risk of atopy. Dietary exposures & allergies prevention (CPS)
• Avoid honey until 1 year of age to prevent botulism.
• Dietary fat content: Restriction of dietary fat during the first 2 years is not recommended since it may compromise the intake of energy and essential fatty acids, required for growth and development. After 2 years, a transition begins from a high fat milk diet to a lower fat milk diet, as per Canada’s Food Guide
• Promote family meals with independent/self-feeding while offering a variety of healthy foods. NHTI: 6-24 months
• Vegetarian diets: Vegetarian diets in children and adolescents (CPS)
• Fish consumption: 2 servings/week of low mercury fish: Fish consumption and mercury (ICG)

ENVIRONMENTAL HEALTH
• Second-hand smoke exposure: There is no safe level of exposure. Advise caregivers to stop smoking and/or reduce second-hand smoke exposure, which contributes to childhood respiratory illnesses, SIDS and neuro-behavioural disorders. Offer smoking cessation resources.
• Sun exposure/sunscreen/insect repellents: Minimize sun exposure. Wear protective clothing, hats, properly applied sunscreen with SPF ≥ 30 for those >6 months of age. No DEET in < 6 months; 6-24 months 10% DEET apply max once daily; 2-12 years 10% DEET apply max TID
• Preventing mosquito and tick bites (CPS)
• Pesticides: Avoid pesticide exposure. Encourage pesticide-free foods.
• Pesticide Exposure in Children (AAP)
  – Lead: There is no safe level of lead exposure in children. Evidence suggests that low blood lead levels can have adverse health effects on a child’s cognitive function.
  – Prevention of Childhood Lead Toxicity (AAP)
  – Lead and Children (CPS)
• Blood Lead Screening is recommended for children who:
  – in the last 6 months lived in a house or apartment built before 1978;
  – live in a home with recent or ongoing renovations or peeling or chipped paint;
  – have a sibling, housemate, or playmate with a prior history of lead poisoning;
  – live near paintsor lead-containing sources of lead contamination;
  – have household members with lead-related occupations or hobbies;
  – are refugees aged 6-months–6 years, within 3 months of arrival and again in 3-6 months.
• Websites about environmental issues:
  – Canadian Partnership for Children’s Health and Environment (CPCHE)
  – AAP Council on Environmental Health
• Transportation in motorized vehicles, including cars, ATVs, snowmobiles, etc.: Child passenger safety (AAP)
• Preventing ATV injuries (CPS) Snowmobile safety (CPS)
  – Children < 13 years should sit in the rear seat. Keep children away from all airbags.
  – Install and follow size recommendations as per specific car seat model and keep child in each stage as long as possible.
  – Use rear-facing infant/child seat that is manufacturer approved for use until at least age 2 years.
  – Use forward-facing child seat after 2 years for as long as manufacturer specifications will allow.
  – Use lap and shoulder belt in the rear middle seat for children over 8 years who are at least 36 kg (80 lb) and 145 cm (4’9”) and fit vehicle restraint system.
• Bicycle: wear bike helmets and advocate for helmet legislation for all ages. Replace if heavy impact or damage. Bicycle helmet legislation (CPS)

INJURY PREVENTION
• Drowning: Prevention of drowning (AAP)
  – Bath safety: Never leave a young child alone in the bath. Do not use infant bath rings or bath seats.
  – Water safety: Recommend adult supervision, training for adults, 4-sided pool fencing, lifejackets, swimming lessons, and boating safety to decrease the risk of drowning.
• Choking:
  – Avoid: hard, small and round, smooth and sticky solid foods until age 3 years. Encourage child to remain seated while eating and drinking. Use safe toys, follow minimum age recommendations, and remove loose parts and broken toys.
  – Use of ipecac is contraindicated in children.
• Falls: Assess home for hazards – never leave baby alone on change table or other high surface; use window guards and stair gates. Baby walkers are banned in Canada and should never be used. Ensure stability of furniture and TV. Advise against turpole use at home. Trampoline use (CPS)
• Safe sleeping environment: Infant assessment on safe sleep (CPS) Homeostatic care (PHAC)
• Sleep position, bed sharing and SIDS: Healthy infants should be positioned on their backs for sleep. Counsel parents on the dangers of other contributory causes of SIDS such as bed sharing, overheating, maternal smoking or second-hand smoke.
• Positional plagiocephaly: While sleep for infants, the orientation of the infant’s head should be varied to prevent positional plagiocephaly; positional interventions should not be used. After unibical cord stump has detached, infants should have supervised dummy time while awake.
• Crib/safety/Room sharing: Infants should sleep in a crib, cradle or bassinet, without soft objects, loose bedding and similar items that meet current 2016 Health Canada regulations. In infants’ room for the first 6 months of life. Room sharing is protective against SIDS.
  – GBS: Proper swaddling of the infant for the first 2 months of life may promote longer sleep periods but could be associated with adverse events (hypothermia, SIDS, or development of hip dysplasia) if misapplied. A swaddled infant must always be placed supine with free movement of hips and legs, and the head uncovered.
  – Pacifier use may decrease risk of SIDS and should not be discouraged in the 1st year of life after breastfeeding is well established, but should be restricted in children with chronic/recurrent otitis media. Pacifier recommendations (CPS)
• Gun safety: Advise on removal of firearms from home or safe storage to decrease risk of unintentional firearm injury, suicide, or homicide. Youth and firearms in Canada (CPS)

OTHER
• Advise parents against using oral cough/cold medications: Restricting Cough and Cold Medications in Children (CPS)
• Complementary and alternative medicine (CAM): Questions should be routinely asked about the use of complementary and alternative medicine, therapy, or products, especially for children with chronic conditions. Natural Health Products (CPS)
• Food allergies: Natural Health Products (CPS)
• Fever advice/temperature: Fever ≥ 38°C in an infant < 3 months needs urgent evaluation. Ibuprofen and acetaminophen are both effective antipyretics. Acetaminophen remains the first choice for antipyresis under 6 months of age; thereafter ibuprofen or acetaminophen may be used. Alternating acetaminophen with ibuprofen for fever control is not recommended in primary care settings as this may encourage fever phobia, and the potential risks of medication error outweigh measurable clinical benefit.
• Temperature measurement (CPS)
• Footwear: Shoes are for protection, not correction. Walking barefoot develops good toe gripping and muscular strength. Footwear for children (CPS)
• Oral Health - Smiles for Life
  – Dental Cleaning: As excessive swallowing of toothpaste by young children may result in dental fluorosis, children under 3 years of age should have their teeth and gums brushed twice daily by an adult using either water (if low risk for tooth decay) or a rice grain sized portion of fluoridated toothpaste if at a high risk for decay. Children 3-6 years of age may be assisted during brushing and only use a small amount (e.g., pea-sized portion) of fluoridated toothpaste twice daily. Caregiver should brush child’s teeth until they develop the manual dexterity to do this alone, and should continue to intermittently supervise brushing after child assumes independence. Begin flossing daily when teeth erupt.
  – Caries risk factors include: smoking, hygiene or diet is concerning, parent has caries, premature or LBW infant, or no water fluoridation.
• To prevent early childhood caries: avoid juices/sweetened liquids and constant sipping of milk or natural juices in both bottle and cup.
• Fluoride varnish should be used for those at caries risk. Consider dietary fluoride supplements only for high risk children who do not have access to systemic community water fluoridation.
• Caries-risk assessment (AAPDA); Fluoride and your child (CDCA)
• Consider the first dentist visit by 6 months after eruption of 1st tooth or at age 1 year.
BEHAVIOUR

Crying
- Excessive crying may be caused by behavioural or physical factors or be the upper limit of the normal spectrum. Caregiver frustration with infant crying can lead to child maltreatment/inflicted injury (head injury, fractures, bruising). The Period of Purged Crying, See Prevention of child maltreatment.

Assess healthy sleep habits
- Normal sleep (quality and quantity for age) is associated with normal development and leads to better health outcomes. Sleeping Behaviour (ESCD).

Recommended sleep duration per 24 hrs: 12-14 hrs (infants 4–12 months); 11-14 hrs (1–2 yrs); 10-13 hrs (3–5 yrs); 9-12 hrs (6–12 yrs); 8-10 hrs (13–18 yrs). Turn off computer/TV screens 60 minutes before bedtime, no computer/TV screens in bedroom. Recommended amount of sleep (AASM).

Night waking
- occurs in 20% of infants and toddlers who do not require night feeding. Counselling around positive bedtime routines (including training the child to fall asleep alone), removing nighttime positive reinforcers, keeping morning awakening time consistent, and rewarding good sleep behaviour has been shown to reduce the prevalence of night waking, especially when this counselling begins in the first 3 weeks of life. Behaviour modification & sleep (MJA). Sleep problems & night wakings (Sleep)

PARENTING/DISCIPLINE

Inform parents that warm, responsive, flexible & consistent discipline techniques are associated with positive child outcomes. Over reactive, inconsistent, cold & coercive techniques are associated with negative child outcomes. Use of physical punishment including spanking should be discouraged in all ages. Effective discipline for children (PSD).

Refer parents of children at risk of, or showing signs of, behavioural or conduct problems to structured parenting programs which have been shown to increase positive parenting, improve child compliance, and reduce general behaviour problems. Access community resources to determine the most appropriate and available research-structured programs. Parenting skills (ESCD). e.g.: The Incredible Years®, Right from the Start, COPE program, Triple P®, Strongest Families

HIGH RISK INFANTS/CHILDREN/PARENTS/CAREGIVERS/FAMILIES

Maternal depression: Physicians should have a high awareness of maternal depression, which is a risk factor for the socio-emotional and cognitive development of children. Although less studied, paternal depression and other family factors may compound the maternal-infant issues. Maternal depression and child development (PSD).

Fetal alcohol spectrum disorder (FASD). Fetal alcohol syndrome (PSD)

Adoption_Foster care: Children newly adopted or entering foster care are a high risk population with special needs for health supervision. Foster Care (PSD); Transractial Adoption (PSD).

Immigrants/refugees: Caring for kids now to Canada (CPS); CRHC Clinical Guidelines.

Aboriginal children: Socialdeterminants of health in Aboriginal children in Canada (PSD).

Social determinants of health (SDH): Inquiry about impact of poverty: “Do you have difficulty in making ends meet? Do you have trouble feeding your family?” Child Poverty Tool (OCFP).

Social determinants of health (CCFPC). Infrastructure to address SDH (PSD).

Prevention of child maltreatment:
- Risk factors for child maltreatment:
  - Parent (low socio-economic status, maternal age < 19 years, single parent family, non-biological parents, abused as child, substance abuse, lack of social support, unplanned pregnancy or negative parental attitude towards pregnancy).
  - Family (spousal violence, poor marital relations, poor child-parent relationship, unhappy family life).
  - Child (behaviour problems, disability).
  - Discuss with parents of preschoolers teaching names of genitalia, appropriate and inappropriate touch, and normal sexual behaviour for age.
  - Exposure to personal violence or other forms of violence has significant impact on physical and emotional well-being of children.

- Assess home visit need: There is good evidence for home visiting by nurses during the perinatal period through infancy for first-time mothers of low socio-economic status, single parents or teenager parents to prevent physical abuse and/or neglect.

Child maltreatment interventions (USPSTF). Bruising in suspected maltreatment cases (PSD).


NONPARENTAL CHILD CARE

Inquire about current child care arrangements. High quality child care is associated with improved paediatric outcomes in all children.

Factors enhancing quality child care include: practitioner general education and specific training; group size and child/staff ratio; licensing and registration/accreditation; infection control and injury prevention; and emergency procedures.

- Guide to child-care in Canada (PSD): Well Being

LITERACY

Encourage parents to read to their children within the first few months of life and to limit TV and computer games to provide more opportunities for reading.

Read, speak, sing, promoting literacy (PSD).

Literacy Promotion (AAP).

Reading aloud to children: the evidence (Arch Dis Child)

FAMILY HEALTHY ACTIVE LIVING/SEDENTARY BEHAVIOURS/SCREEN TIME

Increased physical activity, with parents as role models, through interactive floor-based play for infants and a variety of activities for young children, and decreased sedentary pastimes.

Media use – Counsel on appropriate screen time: < 2 years avoid; 2-4 years < 1 h/day. Less is better. Educational and prosocial programming is better.

- Healthy active living (PSD).

SCREENING

Universal newborn hearing screening (CPS). Newborn screening for auditory atresia (AAP).

Hemoglobinopathy screening: occurs in 20% of infants and toddlers who do not require night feeding. Counselling around positive bedtime routines (including training the child to fall asleep alone), removing nighttime positive reinforcers, keeping morning awakening time consistent, and rewarding good sleep behaviour has been shown to reduce the prevalence of night waking, especially when this counselling begins in the first 3 weeks of life. Behaviour modification & sleep (MJA). Sleep problems & night wakings (Sleep)

INVESTIGATIONS/SCREENING

Anaemia screening: All infants/children from high-risk groups for iron deficiency anemia require screening between 6 and 18 months of age. E.g. Lower SES; Asian; First Nations children; low-birth-weight and premature infants; infants/children fed whole cow’s milk before 9 months of age or at quantities > 750 ml/day, or if iron containing foods are not provided.


Tuberculosis – TB skin testing: For up-to-date information, see Tuberculosis (Gov’t Canada)加拿大 TB Standards: 2nd Edition 2013

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Routine Immunization

- See the Canadian Immunization Guide for recommended immunization schedules for infants, children, youth, and pregnant women, from the National Advisory Committee on Immunization (NACI).
- Provincial/territorial immunization schedules may differ based on funding differences. Provincial/territorial immunization schedules are available at the Public Health Agency of Canada, Ontario Immunization Schedule.
- Immunization pain reduction strategies: During vaccination, pain reduction strategies with good evidence include breastfeeding or use of sweet-tasting solutions, use of the least painful vaccine brand, and consideration of topical anaesthetics. Reducing vaccine pain (CMAJ).
- Acetaminophen or ibuprofen should not be given prior to, but after vaccination as recommended. Preventing vaccine pain (CMAJ).
- Information for physicians on vaccine safety: - Canada's vaccine safety program (CPS) - Autism spectrum disorder: No causal relationship with vaccines (CPS).
- Information for parents on vaccinations can be accessed through:
  - ImmunizeCA
  - Caring for Kids website (CPS) including Your Child's Best Shot
  - A Parent's Guide to Vaccination (PHAC)
  - Working with vaccine-hesitant parents (CPS).

Vaccine Notes
(Adapted websites of NACI and the Canadian Immunization Guide October 2016)

Diphtheria, Tetanus, acellular Pertussis, inactivated Polio virus vaccine and Haemophilus influenzae B (DTaP-IPV-Hib): DTaP-IPV-Hib vaccine may be used for all doses in the vaccination series in children < 2 years of age, and for completion of the series in children 5-7 years old who have received ≥ 1 dose of DPT (whole cell vaccine) (e.g., recent immigrants).

Diphtheria, Tetanus, acellular Pertussis, inactivated Polio virus vaccine, Haemophilus influenzae B and Hepatitis B (Hep B) (DTaP-IPV-Hib-Hep B) is used for 3 of the 4 initial doses in some jurisdictions with routine infant Hep B vaccination programs.

Diphtheria, Tetanus, acellular Pertussis, inactivated Polio virus vaccine (DTaP-IPV) may be used up to age 7 years and for completion of the series in incompletely immunized children 5-7 years old (healthy children ≥5 years of age do not require Hib vaccine).

Tetanus, Diphtheria, Pertussis, Polio (Tdap-IPV) Vaccine, a quadrivalent vaccine containing less pertussis and diphtheria antigen than the preparations given to younger children and less likely to cause local reactions, is used for the preschool booster at 4-6 years of age in some jurisdictions and should be used in all individuals > 7 years of age receiving or completing their primary series.

Diphtheria, Tetanus, acellular Pertussis vaccine – (Tdap): is used for booster doses in people ≥ 7 years of age. All adults should receive at least one dose of pertussis containing vaccine (excluding the adolescent booster). Immunization with Tdap is offered to pregnant women (≥26 weeks of gestation) who have not received an adult dose of pertussis vaccine, to provide immediate protection to infants less than 6 months of age.

Rotavirus vaccine: Universal rotavirus vaccine is recommended by NACI and CPS. Two oral vaccines are currently authorized for use in Canada: Rotarix (2 doses) and RotaTeq (3 doses). Dose #1 is given between 6 weeks and 14 weeks/6 days with a minimum interval of 4 weeks between doses. Maximum age for the last dose is 8 months/0 days.

Recommended for the use of rotavirus vaccines in infants (CPS)

Measles, Mumps and Rubella vaccine (MMR) and MMR-varicella (MMRv): The first dose is given at 12-15 months and a second dose should be given with the 18 month or preschool dose of DTaP-IPV (±Hib) (depending on the provincial/territorial policy), or at any intervening age that is practical but at least 4 weeks after the first if MMR, or 3 months after the first if MMR. If MMR is not used, MMR and varicella vaccines should be administered concurrently, at different sites, or separated by at least 4 weeks.

Varicella vaccine: Children aged 12 months to 12 years who have not had varicella should receive 2 doses of varicella vaccine (univalent varicella or MMRv). Unvaccinated individuals ≥13 years who have not had varicella should receive two doses at least 28 days apart (univalent varicella only). Consult NACI guidelines for recommended options for catch-up varicella vaccination. Varicella and MMR vaccines should be administered concurrently, at different sites if the MMR [combined MMR-varicella] vaccine is not available, or separated by at least 4 weeks. Preventing varicella (CPS).

Hepatitis B vaccine (Hep B):
- Hepatitis B vaccine can be routinely given to infants or preadolescents, depending on the provincial/territorial policy. The first dose can be given at 1 month, or at 2 months of age to fit immunization matrix; the second dose should be administered at least 1 month after the first dose, and the third at least 2 months after the second dose, but again may fit more conveniently into the 4- and 6-month immunization visits. Alternatively, Hep B can be administered as DTaP-IPV-Hib-HepB vaccine in infants, with the first dose at 2 months of age. A two-dose schedule for adolescents is an option.
- For high-risk children, 3 or 4 doses of higher dose of monovalent hepatitis B vaccine is recommended (immunocompromised status, chronic liver disease, cholestasis).
- For infants born to a mother with acute or chronic hepatitis B (HBeAg-positive), the first dose of Hep B vaccine should be given at birth (with Hepatitis B immune globulin, below) and repeat doses of vaccine at 1 and 6 months of age. Premature infants of birthweight less than 2,000 grams born to HB- infected mothers, require four doses of HB vaccine at 0, 1, 2, and 6 months. The last dose should not be given before 6 months of age. Infants of HBsAg-positive mothers also require Hepatitis B immune globulin at birth and follow-up immune status at 9–12 months for HBV antibodies and HBsAg.
- Infants with HBeAg-positive fathers or other household contacts require Hepatitis B vaccine at birth, and at 1 month, and 6 months of age.
- Hepatitis B vaccine should also be given to all infants from high-risk groups, such as:
  - infants where at least one parent has emigrated from a country where Hepatitis B is endemic;
  - infants of mothers positive for Hepatitis C virus;
  - infants of substance-abusing mothers.
- Children in other high risk groups, if not vaccinated in infancy, should be vaccinated as soon as the risk factor is recognized. See Hepatitis B chapter in the Canadian Immunization Guide for a list of high risk groups.

Hepatitis A or A/B combined (HABH - when Hepatitis B vaccine has not been previously given):
- Children 6 months and older in high-risk groups should receive 2 doses of the hepatitis A vaccine given 6-36 months apart (depending on product used). HABH is the preferred vaccine for individuals with indications for immunization against both Hepatitis A and hepatitis B who are ≥12 months unless medical condition indicates high dose Hep B vaccine required.
- These vaccines should also be considered when traveling to countries where Hepatitis A or B are endemic.
- Possible HABH schedules include 12 months to 18 years: 2 doses at months 0 and 6-12; OR 3 doses at months 0, 1, and 6 depending on age and product used.

Pneumococcal vaccine: conjugate (Pneu-C-13) and polysaccharide (Pneu-P-23):
Recommended schedule, number of doses and product depend on the age of the child, risk for pneumococcal disease, and when vaccination is begun. Consult NACI guidelines Routine infant immunization: administer three doses of Pneu-C-13 vaccine at minimum 8-week intervals beginning at 2 months of age, followed by a fourth dose at 12 to 15 months of age. For healthy infants, a three-dose schedule may be used, with doses at 2, 4, and 12 months of age. Children 2 years and above who are at highest risk of invasive pneumococcal disease should receive Pneu-P-23. Consult NACI guidelines for eligibility and dosing schedule.

Meningococcal vaccine:
- Canadian children should be immunized with a MCV-4 at 12 months of age, or earlier depending on provincial/territorial vaccine programs; suggested one dose at 12 months of age.
- MCV-4 (A, C, Y, W) should be given to children two months of age and older who are at increased risk for meningococcal disease or who have been in close contact with a case of invasive meningococcal A,C,Y or W disease. MCV-4-CRM (MenevoTM) should be used for those less than 2 years old; any MCV-4 may be used for older children.
- A routine booster dose with MCV-4 or MCV-C is recommended at approximately 12 years of age. High risk children require boosters at 5 year intervals.
- MCV-4 should be given to children two months of age and older travelling to areas where meningococcal disease is endemic. Meningococcal C CRM (MenveoTM) is recommended for immunization of children 2 months to less than 2 years of age. Any MCV-4 may be used for older children.
- Multi-component meningococcal serogroup B (4CMenB) vaccine should be considered for active immunization of children ≥ 2 months of age who are at high risk of meningococcal disease or who have been in close contact with a case of invasive meningococcal B disease or travelling to an area where risk of transmission of meningococcus B is high. Two to 3 doses are required at 4 or 8 wk intervals depending on age.
- Routine prophylactic administration of acetaminophen after immunization and/or separating 4CMenB vaccination from routine vaccination schedule may be considered for preventing fever in infants and children up to 3 years of age.

Influenza vaccine: Recommended for all children between 6 and 59 months of age, and for older high-risk children.
- Previously unvaccinated children up to 9 years of age require 2 doses with an interval of at least 4 weeks. The second dose is not required if the child has received one or more doses of influenza vaccine during the previous immunization season. A quadrivalent vaccine should be used if available.
- For children between 6 and 23 months, the quadrivalent inactivated influenza vaccine (QIV) should be used, and if not available, either unadjuvanted or adjuvanted trivalent inactivated vaccine (TIV).
- Children 2-18 years of age should be given QIV, or quadrivalent live attenuated influenza vaccine (LAIV) if not contraindicated. Egg allergy is not a contraindication to vaccination with QIV, TIV, or LAIV.
- Immunization with TIV or QIV in the second or third trimester to provide protection for the pregnant woman and infant < 6 months of age.

Respiratory syncytial virus (RSV) vaccine: Palivizumab (Synagis) prophylaxis during RSV season is recommended for children with chronic pulmonary disease, congenital heart disease or born preterm.

Preventing hospitalizations for respiratory syncytial virus infection (CPS).

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Early Child Development and Parenting Resource System

Areas of concern
- Parent/family issues
- Social emotional
- Communication skills
- Motor skills
- Adaptive skills
- Sensory impairment (problems with vision, hearing or feeding)
- Need for additional assessment (more than one developmental area affected)

Parents

Central ‘HUB’ Number
Children’s Services 0-6 Years Public Health

Ontario Early Years Centre

Areas of concern
- Hearing/Speech/Language
- Motor/Vision/Cognitive/Self-help Skills
- Social/Emotional/Behavioural/Mental health/High-risk family

Hearing/Speech/Language

- Infant Hearing Program
- Preschool Speech & Language Program (PSL)
- Specialized medical services (e.g. otolaryngology)
- Services for the hearing impaired

Motor/Vision/Cognitive/Self-help Skills

- Blind Low Vision Program (BLV)
- Children’s Treatment Centre
- Community Care Access Centre (CCAC)
- Infant Development Program (IDP)
- Paediatrician/Developmental Paediatrician
- Services for physical and developmental disabilities
- Services for the visually impaired
- Specialized child care programming
- Specialized medical services (e.g. ophthalmology)

Social/Emotional/Behavioural/Mental health/High-risk family

- Autism Intervention Services
- Children’s Mental Health Services
- Healthy Babies
- Healthy Children (HBHC)
- Infant Development Program (IDP)
- Paediatrician/Developmental Paediatrician

Healthy Babies Healthy Children (HBHC), Public Health, Dental Services, Child Care, Family Resource Programs, Community Parks and Recreation Programs, Schools, Child Protection Services

Local Resources and Referrals

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