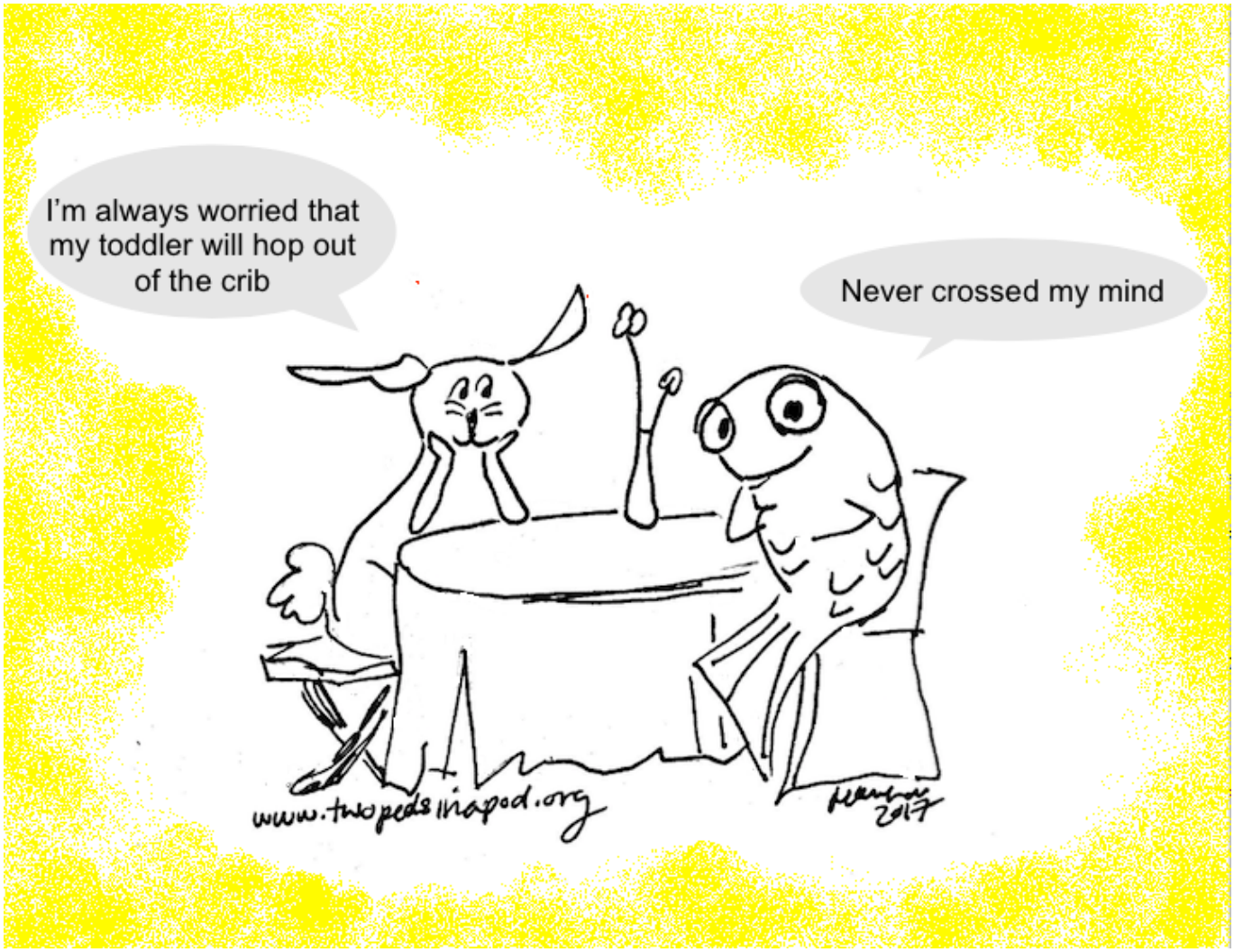
Graduating from Cribtime to Bedtime—how to transition your toddler into a bed



A family asked, "My toddler figured out how to climb out of the crib! How do I transition him into a bed?"

Some kids never climb out of their cribs, but sometimes families need the crib for a new sibling. If this is the case, consider if you really need the crib right away. Using a bassinet for the new baby allows the big brother/sister to get used to having a baby around. Many older siblings regress

after the birth of a sibling and it can be useful to keep the older one in a crib for just a little bit longer, then use the new bed as a reward for "helping" or as a token of increased status.

The scariest part of putting your child into a bed is that your child now has access to his bedroom. So if your child is NOT yet climbing out of the crib, do not rush to transition him out. You first need to childproof the bedroom. Crawl on your hands and knees to see what you can reach. See our post on childproofing. For his safety, gate him into his room or keep the door closed. You may also need to gate the steps or gate a hallway to prevent him from wandering into more dangerous rooms, such as the kitchen, in the middle of the night. We know one family who found their child crawling around on the kitchen counters one morning. Know that open or closed bedroom doors likely do not impact potential fire safety. It is far more important make sure your smoke detectors work.

If you have no reason to break down the crib and your child goes to sleep easily in it, there is no harm in keeping him in his crib. However, once a child is able to climb out, a child is able to fall out. So….time to get out. For many toddlers, the ability to throw a leg over the side of the crib occurs around two years of age or when the toddler reaches three feet tall. If your child is potty trained at this point, he will have easier access to the bathroom at night if he is in a bed rather than a crib, so that is another reason to move to a bed. On the other hand, many kids who are fully potty trained during the day continue to wet the bed for years, so don't wait for dry overnight diapers to put your child into a bed. Just protect the bed mattress with a water-proof liner until your child masters night time dryness.

How to start the transition? You can talk up sleeping in a big boy/big girl bed "just like Mommy and Daddy." Let your toddler pick out sheets or buy him ones you know he will love. For

example, choose sheets in a favorite color, or with favorite characters. Supply a pillow and blanket, but if he is used to a crib without bedding, expect the blanket or pillow to end up off the bed. You might want to continue warm pajamas until a blanket stays on. Sometimes kids want a small “kid’s sized” blanket, but sometimes a larger blanket is more apt to stay on the bed.

While kids are often excited by their new bed, remember that toddlers are creatures of habit. Their excitement might lead them to nap enthusiastically in the bed but then they may want their crib at night. Or they might fight their naps now- remember that many children give up napping between the ages of 2-5 years. If space allows, consider leaving the crib set up for the first week of sleeping in the new bed, then break down the crib once you have several successful naps and overnights in the bed.

Some kids may invite a “friend” or two into his bed: stuffed animals, pacifier, or in the case of one of Dr. Kardos’s kids, a soft Philadelphia Eagles football. Many kids fall asleep with toy cars clutched in their hands. If these friends help your child sleep better, then allow the slumber party.

Falling out of bed is common. For his first week in a bed, Dr Kardos’s first son was always found sleeping peacefully in the middle of his room on the carpet after they tucked him into his bed for the night. You can place a carpet or pillow next to the bed so when the inevitable falling overboard occurs, your child has a softer landing.

You could shorten the distance to the ground by placing a mattress, or a mattress plus the box spring, directly on the floor. Then when your child has gone for a few weeks without falling off the mattress, “build up the bed” onto the standard bedframe.

Alternatively, your child can sleep in a bed with side rails.

Note that portable side rails are made for use only on adult beds, NOT for toddler beds or bunk beds. Guidelines for preventing injury from side rails are found here. Rails are are designed for children aged two to five years who are capable of getting in and out of an adult bed by themselves. According to safety guidelines published by Consumer Reports in 2010, “Be sure they (the rails) fit tightly with no gaps between the mattress and the rail, so that your child can’t get stuck. Leave at least 9 inches between the bed rail and the footboard and headboard of the bed.” The wall is not a bed rail substitute because a child can get trapped between the wall and the mattress.

Decide if you will teach your child to call out to you or to teach him to come into your bedroom if he needs you in the middle of the night. For everyone’s safety, be sure no clothes or clutter between his bed and yours can cause tripping in the dark. A night light in the bathroom helps as well.

As for the beginning of the night, if your child pops out of bed immediately after tucking him in, it’s not too late to teach him how to self-calm and fall asleep in his own bed. This teaching might involve repeated walking him back to bed in a caring manner with minimal conversation besides: “I love you, good night.”

Now your child’s bedtime story will really include a bed! (For instance click here)

Julie Kardos, MD and Naline Lai, MD

Guide to traveling with young children for the holidays

In spite of the long TSA lines, rental car challenges and all the howling, the wolf family made sure they got to grandmother's house every year.

You don't appreciate how much your baby has grown until you attempt a diaper change on a plane. For families, any holiday can become stressful when traveling with young children is involved. Often families travel great distances to be together and attend parties that run later than their children's usual bedtimes. Fancy food and fancy dress are common. Well-meaning relatives who see your children once a year can be too quick to hug and kiss, sending even not-so-shy kids running. Here are some tips for safer and smoother holiday travel:

If you are flying, refrain from offering Benadryl (diphenhydramine) as a way of "insuring" sleep during a flight. Kids can have paradoxical reactions and become hyper

instead of sleepy, and even if they do become sleepy, the added stimulation of flying can combine to produce an ornery, sleepy, tantrum-prone kid. Usually the drone of the plane is enough to sooth kids into slumber.

Know also that **not all kids develop ear pain on planes as they descend-** some sleep right through landing. However, if needed you can offer pacifiers, bottles, drinks, or healthy snacks during take-off and landing because swallowing may help prevent pressure buildup and thus discomfort in the ears. And yes, it is okay to fly with an ear infection.

Before you travel, identify the nearest children's hospital, urgent care center, or pediatrician who is willing to see out-of-town new patients, so that if your child becomes ill enough to need medical care while you are away from home, you will already know where to go.

Traveling 400 miles away from home to spend a few days with close family and/or friends is not the time to solve your child's chronic problems. Let's say you have a child who is a poor sleeper and climbs into your bed every night at home. Knowing that even the best of sleepers often have difficulty sleeping in a new environment, just take your "bad sleeper" into your bed at bedtime and avoid your usual home routine of waking up every hour to walk her back into her room. Similarly, if you have a picky eater, pack her favorite portable meal as a backup for fancy dinners. One exception about problem solving to consider is when you are trying to say bye-bye to the binkie or pacifier.

Supervise your child's eating and do not allow your child to overeat while you catch up with a distant relative or friend. Ginger-bread house vomit is DISGUSTING, as Dr. Kardos found out first-hand when one of her children ate too much of the beautiful and generously-sized ginger bread house for dessert.

Speaking of food, **a good idea is to give your children a**

wholesome, healthy meal at home, or at your "home base," before going to a holiday party that will be filled with food that will be foreign to your children. Hunger fuels tantrums so make sure his appetite needs are met. Then, you also won't feel guilty letting him eat sweets at a party because he already ate healthy foods earlier in the day.

If you have a young baby, **take care to avoid losing control of your ability to protect your baby from germs.** Well-meaning family members love passing infants from person to person, smothering them with kisses along the way. Unfortunately, nose-to-nose kisses may spread cold and flu viruses along with holiday cheer.

On the flip side, there are some family events, such as having your 95-year-old great-grandfather meet your baby for the first time, that are once-in-a-lifetime. **So while you should be cautious on behalf of your child, ultimately, heed your heart**. At six weeks old, Dr. Lai's baby traveled several hours to see her grandfather in a hospital after he had a heart attack. Dr. Lai likes to think it made her father-in-law's recovery go more smoothly.

If you have a shy child, try to **arrive early** to the family gathering. This avoids the situation of walking into a house full of unfamiliar relatives or friends who can overwhelm him with their enthusiasm. Together, you and your shy child can explore the house, locate the toys, find the bathrooms, and become familiar with the party hosts. Then your child can become a greeter, or can simply play alone first before you introduce him to guests as they arrive. If possible, spend time in the days before the gathering sharing family photos and stories to familiarize your child with relatives or friends he may not see often.

Sometimes you have to remember that **once you have children, their needs come before yours**. Although you eagerly anticipated a holiday reunion, your child may be too young to

appreciate it for more than a couple of hours . An ill, overtired child makes everyone miserable. If your child has an illness, is tired, won't use the unfamiliar bathroom, has eaten too many cookies and has a belly ache, or is in general crying, clingy, and miserable despite your best efforts, just leave the party. You can console yourself that when your child is older his actions at that gathering will be the impetus for family legends, or at least will make for a funny story.

Enjoy your CHILD's perspective of holidays: enjoy his pride in learning new customs, his enthusiasm for opening gifts, his joy in playing with cousins he seldom sees, his excitement in reading holiday books, and his happiness as he spends extra time with you, his parents.

We wish you all the best this holiday season!

Julie Kardos, MD and Naline Lai, MD

Updated from our 2009, 2014, and 2015 articles on these topics

---

Prevent spread of germs at the doctor's office

BYOT

Pediatricians are notorious germaphobes. When I sat down for lunch with a pediatrician whom I hadn't seen for years, we greeted each other by simultaneously offering each other hand sanitizer. The last thing we pediatricians want is for your child to pick up a new germ in our office. The American Academy of Pediatrics (AAP) updated guidelines on how to prevent spread of germs in doctors' offices. You are welcome to read the long, unabridged version here. What follows are the highlights about waiting rooms:

On our end:
-Waiting rooms should be equipped with **hand sanitizer or sinks and ideally with masks**.
-Pediatricians should **post visual reminders to cover your/your child's nose and mouth with elbows** rather than hands when coughing and sneezing.
-Pediatricians should also **post visual reminders to dispose of used tissues** properly and promptly.
-All office staff members should **receive the flu vaccine every year and be up to date with all vaccines**.

On your end:

BYOB

Try to BYOT (Bring Your Own Toys). Our staff cannot possibly clean all toys after each use. Also impractical is to have any plush, difficult-to-clean toys for kids in waiting rooms. It

is much less germy for kids to play with their own toys and read their own books brought from home while in the waiting room. Pictured here is a photo of blocks which we dissuaded a kind mom from donating to the office. For this family, BYOB has a new meaning– bring your own blocks to the pediatrician's office and then back home.

These recommendations can easily apply to ANYWHERE you have to wait with your children- the car inspection wait room, the bank, a restaurant, and the gym.

Notably absent from the recommendations is any suggestion of having separate sick and well waiting areas. You may find this surprising. But, as the policy states: " Infected children who are symptomatic should be segregated from well children as quickly as possible. However, no research documents the need for or benefit of separate waiting areas for well and ill children."

In other words, thankfully, your pediatrician's office does not need to build a wall in the waiting room.

Julie Kardos, MD and Naline Lai, MD

Update on teen meningococcal (meningitis) vaccines

Olga Pasick, mom of a teen who died of meningococcal disease, shares her personal experience and information about the updated guidelines.

I wish I had known the importance of vaccination for meningococcal disease before it was too late for my son. Back in September of 2004, David was a happy, healthy 13 year old, who came down with flu-like symptoms one evening. He first felt cold, then spiked a high fever, and vomited throughout the night. In the morning we called the pediatrician to have him seen. Everything ached, and he needed help getting dressed. That's when I noticed purplish spots on his chest and arms. I didn't know how serious that symptom was.

As soon as the doctors saw him, they knew he had meningococcal disease. He was rushed to the ER for a spinal tap and treatment. Unfortunately, the disease spread quickly and his organs failed. David died within 24 hours of first developing those flu-like symptoms from a potentially vaccine-preventable disease. Unbelievable… and heartbreaking.

Meningococcal disease is spread through respiratory droplets, such as coughing or sneezing, or through direct contact with an infected person, such as kissing. About 1 in 10 people are carriers, and don't even know it. It doesn't affect everyone. It is difficult to diagnose because symptoms are similar to

the flu, and include high fever, headache, stiff neck, nausea, vomiting, exhaustion, and a blotchy rash. The disease spreads quickly and within hours can cause organ failure, brain damage, amputations of limbs, and death.

The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend meningococcal vaccination for all 11-18 year olds. The newest recommendation is for permissive use (recommended on a case by case basis) of a type of meningococcal vaccine called meningococcal serotype B. The serotype B vaccine is for ages 16-23, with a preferred age of 16-18. This recommendation joins the long-standing recommendation that all adolescents get meningococcal A, C, W and Y vaccine (this one vaccine protects against these four serotypes) at age 11-12 with a booster dose at 16. The newer serotype B vaccine is particularly important for older adolescents and young adults because it is the most common cause of meningococcal disease in this age group. No vaccine is 100% effective, but it is the best preventative measure we can take.

Because of my experience, I became a member of the National Meningitis Association's (NMA) Moms on Meningitis (M.O.M.s) program. We are a coalition of more than 50 mothers from across the country whose children's lives were drastically affected by this disease, and are dedicated to supporting meningococcal prevention.

Visit the NMA website for more information and to view powerful personal stories of those affected. Talk to your doctor about vaccination. It could save a life. How I wish those recommendations were in place years ago.

Olga Pasick
Wall, New Jersey

Note: In the United States, you may know the meningococcal A, C, W and Y vaccine as either Menactra® or Menveo®. The

serogroup B meningococcal vaccine you may recognize as either Bexsero® or Trumenba®.

The Scoop on Poop: back by popular demand!

Admit it.

Before you became a parent, you never really gave much thought to other people's poop.

Now you are captivated and can even discuss it over meal time: your child's poop with its changing colors and consistency. Your vocabulary for poop has likely also changed. Before your baby's birth, you probably used some grown-up word like "bowel movement" or "stool" or perhaps some "R" rated term not appropriate to this pediatric site.

We pediatricians have many conversations with new parents, and some not-so-new parents, about poop. Mostly this topic is of great interest to parents with newborns, but this issue come out at other milestones in a child's life, namely when starting solid foods and during potty training.

Poop comes in three basic colors that are all equal signs of normal health: **brown, yellow, and green.** Newborn stool, while typically yellow and mustard like, can occasionally come out in the two other colors, even if what goes in, namely breast milk or formula, stays the same. The color change is more a reflection of how long the milk takes to pass through the intestines and how much bile acid gets mixed in with the developing poop.

Bad colors of poop are: red (blood), white (complete absence of color), and tarry black. Only the first stool that babies pass on the first day of life, called meconium, is always tarry black and is normal. At any other time of life, black tarry stools are abnormal and are a sign of potential internal bleeding. You should always discuss with your child's doctor black poop, blood in poop (this is not normal), and white poop (which could indicate a liver problem).

Normal pooping behavior for a newborn can be grunting, turning red, crying, and generally appearing as if an explosion is about to occur. As long as what comes out after all this

effort is a soft (normal poop should always be soft), then this behavior is normal. Other babies poop effortlessly and this, too, is normal.

Besides its color, another topic of intense fascination to many parents is the **frequency and consistency** of poop. This aspect is often tied in with questions about diarrhea and constipation. Here is the scoop:

It is normal for newborns to poop during or after every feeding, although not all babies go this often. This means that if your baby feeds 8-12 times a day, then she can have 8-12 poops a day. One reason that newborns are seen every few weeks in the pediatric office is to check that they are gaining weight normally. Good weight gain means that calories taken in are enough for growth and are not just being pooped out. While normal poop can be very soft and mushy, diarrhea is watery and prevents normal weight gain.

After the first few weeks of life, a **change in pooping frequency** can occur. Some formula fed babies will continue their frequent pooping while others decrease to once a day or even once every 2-3 days. Some breastfed babies actually decrease their poop frequency to once a week! These babies' guts digest breast milk so efficiently that they are left with little waste product.

As long as these less-frequently-pooping babies are feeding well, not vomiting, acting well, have soft bellies rather than hard, distended bellies, and are growing normally, then parents and other caregivers can enjoy the less frequent diaper changes. Urine frequency should remain the same (at least 6 wet diapers every 24 hours, on average) and is a sign that your baby is adequately hydrated. Again, as long as what comes out in the end is soft, then your baby is not "constipated" but rather has "decreased poop frequency."

True constipation is poop that is hard and comes out as either

small hard pellets or a large hard mass. These poops are often painful to pass and can cause small tears in the anus. You should discuss true constipation with your child's health care provider. A typical remedy, assuming that everything else about your baby is okay, is adding a bit of prune or apple juice, generally ½ to 1 ounce, to the formula bottle once or twice daily. True constipation in general is more common in formula-fed babies than breastfed babies.

Adding solid foods generally causes poop to become more firm or formed, but not always. It DOES always cause more odor and can also add color. Dr. Kardos still remembers her surprise over her eldest's first "sweet potato poop" as she and her husband asked each other, "Will you look at that? Isn't this exactly how it looked when he ATE it?" If constipation, meaning hard stools that are painful to pass, occurs during solid food introductions, you can usually help soften up the poop by giving more prunes and oatmeal and less rice and bananas.

Potty training can trigger constipation resulting from poop withholding. This withholding can result in backup in the intestines which leads to pain and poor eating. Children withhold for one of three main reasons:

1. They are afraid of the toilet or potty seat.
2. They had one painful poop and they resolve never to repeat the experience by trying to never go again.
3. They are locked into a control issue with their parents. Recall the truism "You can lead a horse to water but you can't make him drink." This applies to potty training as well.

Treatment for stool withholding is to QUIT potty training for at least a few weeks and to ADD as much stool softening foods and drinks as possible. Good-for-poop drinks and foods include prune juice, apple juice, pear juice, water, fiber-rich breads and cereals, beans, fresh fruits and vegetables. Sometimes,

under the guidance of your child's health care provider, children need medical stool softeners or laxatives until they overcome their fear of pooping. For more information about potty training we refer you to our post with podcast on this subject.

Our goal with this blog post was to highlight some frequently-asked-about poop topics and to reassure that **most things come out okay in the end.** And that's the real scoop.

Julie Kardos, MD and Naline Lai, MD

Got little kids? One must-have number to put in your phone: Poison Control

The number to put in your phone when you have little ones? Poison Control: **1-800-222-1222**. Text "POISON" TO 797979 to save the contact information in your smartphone.

Did your toddler eat dog poop? Or a berry from your backyard bush? Did you give the wrong medication to your child? **Call Poison Control**.

Experts at Poison Control will direct your next step. They have access to extensive data on poisoning, and they can give you that information much quicker than a drug-manufacturer or pharmacist or even your own doctor. **The call is free**.

One of Dr. Lai's kids ate a mushroom from the yard when she was 20 months old—she called Poison Control. A mom asked Dr. Lai about carbon monoxide exposure—she called Poison Control. If doctors have a question about any ingestion or poisoning—we call Poison Control. But don't wait for us to call, go ahead yourself and call.

People often jump first to the internet for information. However, a small 2013 study found that the internet is NOT the best place to research questions about toxins. Many sites fail to direct readers to the Poison Control Center, and those who do, fail to supply the proper phone number – again, that's **1-800-222-1222**. If you do want to use the internet, use www.PoisonHelp.org which is a product of the American Association of Poison Control Centers

If your child needs emergent treatment, surfing the internet for what to do next wastes precious time. Don't reach for your phone to "google it." In the case of a possible poisoning, reach for your phone and make a CALL.

It could be life-saving.

Julie Kardos, MD and Naline Lai, MD

Cell phones, routers and electromagnetic radiation

At college drop off last week, my husband noticed an object that looked suspiciously like a router in our kid's dorm room. Vaguely aware that routers emit some sort of radiation, I turned to environmental medicine expert Dr. Alan Woolf for

information, here is what he shared:

Q: My daughter has a wireless router within 2 feet of where she sleeps. Is this a problem?

A: The answer to the question is unfortunately not a straightforward 'no problem'. Routers are one of a number of devices, including tablets, cell phones, and cell towers, that give off electromagnetic radiation (EMR) or radiofrequency radiation (RFR). In 2013 more than 6.8 billion mobile phones were registered.

Animal studies of EMR/RFR shows some biological effects, but it is uncertain whether these are applicable to humans. Human studies (and there have been many) have been either inconclusive or negative and are frequently confounded by problems with their design. However one well-controlled, blinded 2015 study of 31 adult females (average age: 26 years) holding 3G mobile phones near their heads for 15 minutes showed evidence of changes in their brain waves on EEG. Whether these changes were long-lasting or of any health import are unanswered questions. The International Agency for Research on Cancer (IARC), part of the United Nations' World Health Organization, said in June 2011 that a family of frequencies that includes mobile-phone emissions is "possibly carcinogenic to humans."

Federal agencies, such as the NIOSH, FCC and FDA, have set safety standards for mobile phones, routers, cell towers, etc. that are inclusive of safety factors for EMR/RFR emissions for humans; no commercial devices can be sold in the U.S. that do not comply with such standards. RFR energy levels from Wi-Fi equipment in all areas accessible to the general public, including school settings, are required to meet Federal exposure guidelines. The limits specified in the guidelines are based on an ongoing review of thousands of published scientific studies on the health impacts of RFR energy. Levels of RFR energy emitted from Wi-Fi equipment are typically well

below these exposure limits. As long as exposure is below these established limits, there is no convincing scientific evidence that emissions from this equipment are dangerous to schoolchildren or to adults. There is no scientific evidence of long-term or cumulative health effects of RFR in children.

Wireless routers in commercial use are very low energy devices and are not a safety concern. Still, It seems prudent to keep some distance away from EMR/RFR emitters when chronic exposure is likely. The strength (and therefore dose) of EMR/RFR is exponentially inversely proportional to distance from the emission. Apple Inc. itself recommends, for example, that mobile phones be held at least 5/8 inch away from the body, or that Bluetooth-type headphone devices be used to keep the head away from the phone emitter.

In reality, EMR/RFR waves are all around us (just see what happens when your cell phone is 'searching' for a signal—sometimes it finds half a dozen or more in your vicinity). Unfortunately the medical safety science has not kept up with advances in the technology and so there continue to be uncertainty and unanswered health questions concerning their safety.

Alan Woolf, MD, MPH

We thank Dr. Woolf for his insight, and Dr. Lai is happy to report that her daughter gets great wi-fi reception. Alan Woolf, MD, MPH is Professor of Pediatrics, Harvard Medical School (HMS), attending physician at Boston Children's Hospital (BCH) and has authored over 250 original reports, scientific reviews, chapters, and other publications, many of them on topics concerning children's poisoning and toxic environmental exposures. Among other accolades he is a past-president of the American Association of Poison Control Centers (AAPCC), and immediate past-president of the American

Academy of Clinical Toxicology (AACT). Dr. Woolf has also served as external consultant to the World Health Organization's International Program in Chemical Safety and as a member of the National Advisory Committee for Acute Exposure Guideline Levels for Hazardous Substances, EPA. He was recently chosen as a member of the General Hospital & Personal Use Device Panel of the Food & Drug Administration (FDA) and also serves as a consultant to the Medical Devices Advisory Committee of the Center for Devices and Radiological Health of the FDA.

What's new with the flu vaccine 2017-2018

“What? The flu vaccine again? We JUST got it,” our kids groaned when we told them it was time to get their flu vaccines. In fact, they “just got it” a year ago, which we pointed out to them. Read on to see updates on this year’s flu vaccine and why it should be on your child’s back to school to do list.

This year’s flu vaccine is slightly different from last year’s– it’s been changed to cover a different strain of circulating H1N1 influenza. Several flu vaccines have been FDA approved for this year’s flu season and all of them will give

similar protection for your child. Make sure your child receives a flu shot and NOT the FluMist/spray-in-the-nose kind of vaccine. Unfortunately for those who are needle phobic, the FluMist has not been shown to be effective and therefore, while still licensed, is NOT recommended for use this year.

The flu vaccine is recommended for **all kids six months of age and older**, with very few exceptions. Even pregnant moms safely can receive the flu vaccine.

Too early for flu vaccine? Nope! Older adults might lose some immunity if vaccinated "too soon" in the season, but this observation is not born out in kids. The threat of incomplete or forgotten vaccine outweighs theoretical risk of delaying flu vaccine (even for older adults), so best to get it now.

In case you forgot, the flu is a week of misery, consisting of high fevers, cough and other respiratory symptoms, body aches, and headaches. Younger kids are prone to some diarrhea or vomiting or both along with these bad cold symptoms. The flu can cause dehydration and pneumonia, and sometimes death, even in previously healthy kids. Simply limiting your child's exposure to people showing flu symptoms is not an effective way of preventing illness because people are the most contagious right before they show any symptoms.

Booster dose As in previous years, children under nine years of age need a booster dose the first year they receive the vaccine. If your young child should have received a booster dose last year, but missed it, they will receive two doses of this year's vaccine spaced one month apart (the primary dose plus a booster dose).

This prior post teaches you how to tell if your kid has flu vs "just" a cold. We invite you to read more about this year's flu vaccine on the Centers for Disease Control website here.

Julie Kardos, MD and Naline Lai MD

First day of kindergarten-a letter to your child

Whether your child is about to start kindergarten or college, we invite you to read Dr. Lai's letter she wrote to her first born the night before she started kindergarten. Spoiler: You might want to grab a tissue.

My Child,

As we sit, the night before kindergarten, your toes peeking out from under the comforter, I notice that your toes are not so little anymore.

Tomorrow those toes will step up onto to the bus and carry you away from me. Another step towards independence. Another step to a place where I can protect you less. But I do notice that those toes have feet and legs which are getting stronger. You're not as wobbly as you used to be. Each time you take a step you seem to go farther and farther.

I trust that you will remember what I've taught you. Look both ways before you cross the street, chose friends who are nice to you, and whatever happens don't eat yellow snow. I also trust that there are other eyes and hearts who will watch and guide you.

But that won't stop me from worrying about each step you take.

Won't stop me from holding my breath.

Just like when you first started to walk, I'll always worry when you falter.

I smile because I know you'll hop up onto the bus tomorrow, proud as punch, laughing and disappearing in a sea of waving hands. I just hope that at some point, those independent feet will proudly walk back and stand beside me. Maybe it will be when you first gaze into your newborn's eyes, or maybe it will be when your child climbs onto the bus for the first time.

Until then, I hold my breath each time you take a step.

Love,
Mommy

Naline Lai, MD

Get your child back on a school sleep schedule

Great-horned owl, NPS Photo, Big Bend National Park

Okay, we admit it: our kids are still in their summertime sleep mode of stay up late/sleep late. With school starting soon, many of us now have to shift our children from summer to school year sleep schedules. Because school start times are constant (and early), the kids will have an easier time if you help them shift their bedtimes gradually over the period of a week or two toward the desired earlier bedtime. Remember, the average school-aged child needs 10-11 hours of sleep at night and even teenagers function optimally with 9-10 hours of slumber per night.

Here are some straight forward ways to help ensure good quality sleep for your child:

1. **Keep sleep onset and wake up times as consistent as possible 7 days a week**. If you allow your child to

"sleep in" during the weekends, she will have difficulty falling asleep earlier on Sunday night, have difficulty waking up Monday morning, and start off her week over-tired, more cranky, and less able to process new information—not good for learning. That said, you can allow your teens, who generally have a much earlier school start time than their biological clocks desire, to sleep in an hour or so on weekends to catch up on sleep.

2. **Limit or eliminate caffeine intake**. Often teens who feel too sleepy from lack of sleep drink tea, coffee, "energy drinks" or other caffeine laden beverage in attempt to self-medicate in order to concentrate better. What many people don't realize is that caffeine stays in your body for 24 hours so it is entirely possible that the caffeine ingested in the morning can be the reason your child can't fall asleep later that night. Know also that kids who drink "pre-work out" drinks may not realize that caffeine is one of the ingredients. Better to pre-hydrate with water. Caffeine can have side effects of jitteriness, heart palpitations, increased blood pressure, and gastro-esophageal reflux (heartburn). If your child already has a daily ice-tea, coffee, or other caffeine containing drink, let her wean down gradually- abrupt caffeine withdrawal can cause headaches.
3. **Keep a good bedtime routine**. Just as a soothing, predictable bedtime ritual can help babies and toddlers settle down for the night, so too can a bedtime routine help prepare older kids for sleep. Prevent your child from doing homework on his bed- better to associate work with a desk or the kitchen table and his bed with sleep.
4. **Avoid TV/computer/ screen time/smart phones just before bed**. Although your child may claim the contrary, watching TV is known to delay sleep onset. We highly recommend no TV in a child's bedroom, and suggest that parents confiscate all cell phones and electronic toys, which kids may otherwise hide and use without parent

knowledge, by one hour prior to bedtime. Quiet activities such as taking a bath, reading for pleasure, and listening to music are all known to promote falling asleep. Just be sure your kids put down the book, turn off the music, and turn off the light to allow time to relax in their beds and fall asleep. Many use this time for prayer or meditation.

5. **Encourage regular exercise**. Kids who exercise daily have an easier time falling asleep at night than kids who don't exercise. Gym class counts. So does playing outside, dancing, walking, and taking a bike ride. Participating in a team sport with daily practices not only helps insure better sleep but also has the added benefit of promoting social interactions

Getting enough sleep is important for your child's academic success as well as for their mental health. We pediatricians have had parents ask about evaluating their children for attention-deficit hyperactivity disorder because of an inability to pay attention, only to find that their youngster's focusing issues stem from tiredness. Teens are often so over-involved in activities that they average 6 hours of sleep or less per night. Increasing the amount of sleep in these kids can alleviate their attention problems and resolve their hyperactivity.

Additionally, sleep deprivation can cause symptoms of depression. Just recall the first few weeks of having a newborn: maybe you didn't think you were depressed but didn't you cry from sheer exhaustion at least once? A cranky kid or sullen teen may become much more upbeat and pleasant if they get an extra hour of sleep each night.

Unfortunately for children, the older they get, their natural circadian rhythm shifts them toward the "night owl" mode of staying up later and sleeping later, and yet the higher-up years in school start earlier so that teens in high school start school earliest at a time their bodies crave sleeping

late. A few school districts in the country have experimented with starting high school later and grade school earlier and have met with good success. Unless you live in one of these districts, however, your teens need to conform until they either go to college and when they can choose classes that start later in the day or choose a job that allows them to stay up later and sleep later in the day.

For kids of all ages, a night time ritual of “tell me about your day” can help kids decompress, help them fall asleep, and keep you connected with your child.

Julie Kardos, MD and Naline Lai, MD