

PREGLED LITERATURE – REVIEW ARTICLE

Paediatric Well Child Care in the First Year of Life

Pedijatrijski pregledi i imunizacija u prvoj godini života

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Summary Well child care is a discipline within paediatrics that evaluates the progression of a patient's nutrition, development, psychosocial advancement, physical examination, and immunization status at specific time points throughout childhood. One vital component of well child care is to designate time for age-appropriate anticipatory guidance about upcoming developmental milestones; therefore promoting optimal health and preventing injury. Many countries developed nationally recognized preventive programs for the first year of life including the immunization schedule. In many countries worldwide general practice physicians and/or nurses supervise child development and immunizations. The article summarizes well child care in the United States in the first year of life recommendations provided by The American Academy of Paediatrics.

Key words: infants, development, immunization

Sažetak Razvojna pedijatrija je posebna disciplina u okviru pedijatrije, koja se bavi praćenjem rasta i razvoja deteta, ishranom, psihosocijalnim aspektom, sistematskim pregledima i imunizacijom. Jedan od zadataka razvojne pedijatrije je utvrditi kliničke vodiče koji omogućavaju praćenje razvojnih karakteristika prema uzrastu, ali i ostali zadaci su bitni - promocija optimalnog zdravstvenog stanja i prevencija povredjivanja. Mnoge zemlje imaju nacionalne programe za preventivnu pedijatriju u prvoj godini života, uključujući i precizno definisane šeme imunizacije. U nekim zemljama, ovaj posao sprovode lekari opšte prakse i /ili obučene meidinske sestre. Imajući u vidu, razlike u izvođenju ovih programa preventivne pedijatrije u Sjedinjenim američkim državama, želimo da iznesemo preporuke koje je izdalo Američko udruženje za pedijatriju.

Ključne reči: deca, razvoj, imunizacija

Introduction

Paediatricians have the privilege to help build a child's foundation in health that will guide them into adulthood (1). Well child care is a discipline within paediatrics that evaluates the progression of a patient's nutrition, development, psychosocial advancement, physical examination, and immunization status at specific time points throughout childhood. One vital component of well child care is to designate time for age-appropriate anticipatory guidance about upcoming developmental milestones; therefore promoting optimal health and preventing injury (1). Many European countries, such as France and Sweden, have general practice physicians and/or designated nurses that supervise general development and immunizations, only referring patients to a paediatrician for care outside their scope of practice (2). In the United States, paediatricians provide both well child care and treat acute illnesses in a primary care setting, an established "medical home".

The American Academy of Paediatrics (AAP) and *Bright Futures* recommend that children receive twenty-nine well child visits between birth and 21 years of age (Figure 1); eleven of them within the first three years of life (1). This article outlines paediatric well child care in America in the first year of life, with recommended visits at birth, 1 month, 2 months, 4 months, 6 months, 9 months, and 12 months of age.

In America, well child care begins before newborn hospital discharge and is focused on disease screening. All neonates receive the newborn screening panel blood test, a state-dependent selection of diseases with results tracked in a national registry. This screening focuses on illnesses where proper early therapy can slow disease progression and improve outcomes (3). Panels concentrate on conditions such as, cystic fibrosis, sickle cell anemia, congenital hypothyroidism, and inborn errors of metabolism (3). The next preventative testing is critical congenital heart disease (CCHD) screening, performed when the patient is greater than 24 hours old. By obtaining pre- and post-ductal

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

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

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

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

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

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AGE	INFANCY										EARLY CHILDHOOD										MIDDLE CHILDHOOD										ADOLESCENCE									
	Prevalent*	Newborn	3-6 mo	7-12 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3-4 y	4-5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y													
HISTORY																																								
Initial Interview	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
MEASUREMENTS																																								
Length/Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Head Circumference	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Weight for Length	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Body Mass Index	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
SENSORY SCREENING																																								
Vision	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Hearing	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																								
Developmental Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Autism Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Psychosocial/Behavioral Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Alcohol and Drug Use Assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Depression Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
PHYSICAL EXAMINATION																																								
PROCEDURES*																																								
Newborn Blood Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Critical Congenital Heart Defect Screening (noninvasive)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Hemoglobin or Hemoglobin (noninvasive)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Lead Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Tuberculosis Testing	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Dyslipidemia Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
STI/HIV Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
Cervical Dysplasia Screening	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•												
ORAL HEALTH*																																								
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•											

1. If a child cannot be seen for the first year, any part of the schedule, or if any item is not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

2. A general visit is recommended for parents until a high risk for breast and/or cervical cancer, for those who request a conference. The general visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Breast Feed: <http://pediatrics.aappublications.org/content/124/4/1227.full>

3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (read instruction and support should be offered). Every infant should have an evaluation within 1 to 3 days of birth and within 4 to 12 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk": <http://pediatrics.aappublications.org/content/129/4/1040.full>. Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2012 AAP statement "Hospital Discharge for Healthy Term Newborns": <http://pediatrics.aappublications.org/content/129/2/316.full>.

4. Screen, per the 2007 AAP statement "Expert Consensus Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report": <http://pediatrics.aappublications.org/content/119/5/1083.full>

5. Blood pressure measurement in infants and children with history of cardiac disorders should be performed at 18 to 24 months of age.

6. If the patient is uncooperative, re-screen within 6 months, per the 2007 AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians": <http://pediatrics.aappublications.org/content/120/4/898.full>

7. All newborns should be screened per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs": <http://pediatrics.aappublications.org/content/119/5/1083.full>

8. See 2009 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Screening and Referral": <http://pediatrics.aappublications.org/content/124/1/100.full>

9. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders": <http://pediatrics.aappublications.org/content/120/3/1183.full>

10. A recommended screening tool is available at <http://www.aasap.org/assess/2007/7/14/14a.pdf>

11. Recommended screening tool is available at <http://www.aasap.org/assess/2007/7/14/14a.pdf>

12. Recommended screening tool is available at <http://www.aasap.org/assess/2007/7/14/14a.pdf>

13. At each visit, age appropriate physical examination is essential, with clinical utility indicated and often (often unmet) and subtly stated. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient": <http://pediatrics.aappublications.org/content/127/5/991.full>

14. These may be modified, depending on entry point to the schedule and individual need.

15. The Recommended Uniform Newborn Screening Panel: <http://www.hrsa.gov/advisorycommittees/mchadvisorycom/heritabledisorders/recmmendedpanel/uniformscreeningpanel.pdf>, as determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening investigators: http://www.cdc.gov/ncbhd/lead/ACCLPP/Final_Document_030712.pdf

16. Follow-up must be provided, as appropriate, by the pediatrician.

17. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease": <http://pediatrics.aappublications.org/content/126/3/583.full>

18. Schedule, per the AAP Committee on Infectious Diseases, are available at <http://www.aasap.org/assess/2007/7/14/14a.pdf>

19. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children 0-3 Years of Age": <http://pediatrics.aappublications.org/content/125/2/405.full>

20. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention": http://www.cdc.gov/ncbhd/lead/ACCLPP/Final_Document_030712.pdf

21. Pediatric risk assessment is knowledge as appropriate, based on universal screening questions for patients with Medicaid (in a high prevalence area).

22. Tuberculosis screening recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book, Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.

23. See AAP endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents": <http://www.nhlbi.nih.gov/health/heartandlung/>

24. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book, Report of the Committee on Infectious Diseases. Additionally, all adolescents should be screened for HIV according to the AAP statement "HIV Testing and Counseling in Pediatric Patients Between the Ages of 13 and 18, Making Every Effort to Preserve Confidentiality of the Adolescent": <http://pediatrics.aappublications.org/content/126/3/583.full>

25. See USPSTF recommendations: <http://www.uspreventiveserVICES.org/uspstf/12/02/02a.html> Indications for public examinations prior to age 21 are noted in the 2010 AAP statement "Optimizing Eye Examinations in the Pediatric Office Setting": <http://pediatrics.aappublications.org/content/127/5/991.full>

26. Refer to a general home visit, if available, perform a risk assessment.

27. If primary water source is different in fluoride, consider oral fluoride supplementation. For those at high risk, consider application of fluoride varnish for caries prevention. See 2008 AAP statement "Preventive Oral Health Intervention for Pediatricians": <http://pediatrics.aappublications.org/content/122/6/1187.full> and 2009 AAP statement "Oral Health Risk Assessment, Timing and Establishment of the Dental Home": <http://pediatrics.aappublications.org/content/121/5/1113.full>

KEY: • = to be performed; * = risk assessment to be performed with appropriate action to follow, if positive; ← → = range during which a service may be provided

Summary of changes made to the 2014 Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

Changes to Developmental/Behavioral Assessment

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

Changes to Procedures

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

For several recommendations, the AAP Policy has been updated since 2007 but there have been no changes in the timing of recommendations on the Periodicity Schedule. These include:

- Footnote 2- The Prenatal Visit (2009): <http://pediatrics.aappublications.org/content/124/4/1227.full>
- Footnote 4- Breastfeeding and the Use of Human Milk (2012): <http://pediatrics.aappublications.org/content/129/4/1040.full> and Hospital Stay for Healthy Term Newborns (2010): <http://pediatrics.aappublications.org/content/125/2/405.full>
- Footnote 8- Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs (2007): <http://pediatrics.aappublications.org/content/120/4/898.full>
- Footnote 10- Identification and Evaluation of Children with Autism Spectrum Disorders (2007): <http://pediatrics.aappublications.org/content/120/3/1183.full>
- Footnote 17- Immunization Schedules (2014): <http://pediatrics.aappublications.org/content/125/2/405.full>
- Footnote 19- CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (2012): http://www.cdc.gov/ncbhd/lead/ACCLPP/Final_Document_030712.pdf
- Footnote 22- AAP-endorsed guideline "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (2011): <http://www.nhlbi.nih.gov/health/heartandlung/>
- Footnote 25- Preventive Oral Health Intervention for Pediatricians (2008): <http://pediatrics.aappublications.org/content/122/6/1187.full> and Oral Health Risk Assessment, Timing and Establishment of the Dental Home (2009): <http://pediatrics.aappublications.org/content/121/5/1113.full> Additional information from the policies regarding fluoride supplementation and fluoride varnish has been added to the footnote.

New references were added for several footnotes, also with no change to recommendations in the Periodicity Schedule:

- Footnote 5- Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (2007): http://pediatrics.aappublications.org/content/120/Supplement_4/5164.full
- Footnote 13- Use of Chaperones During the Physical Examination of the Pediatric Patient (2011): <http://pediatrics.aappublications.org/content/127/5/991.full>
- Footnote 15- The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchadvisorycom/heritabledisorders/recmmendedpanel/uniformscreeningpanel.pdf>), as determined by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes.cdc.gov/genetics/gene/gene.html>), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

For consistency, the title of "Tuberculin Test" has been changed to "Tuberculosis Testing." The title of "Newborn Metabolic/Hemoglobin Screening" has been changed to "Newborn Blood Screening."

Figure 1. Recommendations for Preventive Paediatric Health Care

oxygen saturations, usually in the right hand and one foot, critical cyanotic heart lesions can be identified that may have missed on prenatal ultrasound (4).

A pulse oximetry reading greater than or equal to 95% in either extremity with a less than or equal to 3% difference between extremities is considered a pass; any failed screen requires further testing and/or evaluation by a paediatric cardiologist (4). Finally, the AAP recommends all babies receive a hearing screen within the first month of life called Auditory Brainstem Evoked Response testing or ABER (5). This testing evaluates a baby's brain response to sound, even while the infant is sleeping. Most infants have this performed before hospital discharge and will follow up with audiology for a failed screen. Any infant identified with

hearing impairment should receive therapy by six months of age; thus fostering speech and language skills, academic progression, and social-emotional development (5).

After hospital discharge, preventative care continues with a primary care paediatrician. The first office visit is at about 3-5 days of life to establish care and evaluate feeding, weight, and jaundice risk factors (6). Anticipatory guidance by the paediatrician addresses issues including car seat safety, tobacco avoidance, and safe sleep. Families are also educated that a fever of 38 Celsius or greater is considered a medical emergency requiring medical evaluation for sepsis. Finally, the first vaccine recommended by the Centers for Disease Control and Prevention immunization

schedule is for Hepatitis B, given either upon hospital discharge or during this first appointment (7).

The next recommended visit by the AAP is by one month of life to again monitor growth during this critical time of development (6). For these and all future visits, referenced by Figure 1, the AAP recommends evaluation of length, weight, head circumference, and weight for length growth parameters. These values are plotted on growth curves and percentiles are followed at each future visit. In addition, vision, hearing, and developmental and behavioral assessments are completed. Anticipatory guidance at this age reinforces the teaching from birth and after hospital discharge.

Subsequent visits for examination and immunization are at two, four, and six months of age. Growth and development are again assessed while providing evaluation of age-specific milestones (6). Anticipatory guidance focuses on prevention of Sudden Infant Death Syndrome (SIDS), proper nutrition, and illness prevention. Early on, sleep routines are discussed with parents encouraging babies to be placed on their backs to sleep.

At the four month visit, paediatricians will discuss the introduction of solid food often beginning with rice cereal. Before babies become mobile, safety proofing of the home is an important topic to be addressed to prevent infant injury. Scheduled vaccines at these three visits include Rotavirus, Hepatitis B, Diphtheria, Tetanus, Acellular Pertussis, Haemophilus Influenza Type B, Pneumococcal Conjugate Valence 13, and inactivated Poliovirus. During influenza season, the first vaccine dose can be given at 6 months of age with a second dose 4 weeks later (7).

The next well-child visit at 9 months focuses specifically on childhood development. Specific screening measures are utilized to evaluate parental observation of milestone attainment. The Parents' Evaluation of Developmental Status (PEDS) is a screening tool used to identify delays and problems in behavior that may need further evaluation (8). It focuses on gross and fine motor development and communication skills. Example questions include evaluating for eye contact and pincer grasp at 9 months of age. By identifying deficiencies, children can be referred for more testing and/or therapy. Early intervention is vital in ensuring the child reaches their full neurodevelopmental potential (8). Resources are provided at the state level until preschool age. Anticipatory guidance continues to address the safety of a very active baby who may already be crawling. The paediatrician will also likely encourage foods with a variety of textures and starting healthy snacks. There are often no vaccinations given at the 9 month visit, though this is clinic dependent.

The final preventative visit of the first year is at 12 months. In addition to routine assessments, the one year well child visit consists of screening for iron deficiency anemia and lead poisoning that can lead to neurologic impairment (9). In the United States, lead poisoning found in house paint is a primary cause of anemia and families are routinely educated about this hazard. This is also the appropriate time for fluoride varnish to be applied to teeth,

either in the dentist or paediatrician's office. When applied every 6 months up to 3 years of age, fluoride treatment reduces caries by 38% over a two year span (10). If they have not yet started, children are encouraged to start brushing teeth at last two times a day. Paediatricians also prepare parents for the upcoming milestones of walking and language acquisition emphasizing a safe environment free of potential harm. Finally, this visit includes first doses of Measles, Mumps, Rubella, Varicella, and Hepatitis A vaccines (7).

Well child visits are the cornerstone of preventative paediatric care. The physician spends these appointments evaluating the health of the child and providing education to the entire family. By having well-established guidelines established by the AAP, paediatricians can monitor growth and development at fixed intervals and provide age-specific screening. Delivery of thorough and effective well child care allows paediatricians to assist children and their parents prevent illness and develop healthy habits that will follow them for a lifetime.

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