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Red Light Green Light

Each April, **FocusDriven** increases its efforts to combat cell phone distracted driving and encourages individuals to drive cell free. We all have a role to play in making our roadway community safer. One action we can all take is to support driving cell free.

To learn more about the dangers of distracted driving, and to take a pledge to drive cell-phone free, visithttp://focusdriven.org/content.asp?tid=115

Car Seat Recommendations for Children

Car Seat guidelines are ever changing, but there are a several guidelines that should always be followed to keep your child safe.

Birth-12 Months: Children under age 1 should always ride in a rear-facing car seat in the back seat.

1-3 Years: Keep children rear-facing as long as you can as this is the best way to protect your child. Children should be in a rear-facing car seat until he or she is at the maximum height and weight limit set by the car seat's manufacturer. When the child has outgrown rear-facing car seats, he or she can graduate to a forward-facing car seat with a harness.

4-7 Years: Children can travel in a booster seat, in the back seat of the car, when they outgrow forward-facing car seats with a harness.

8-12 Years: A child may use a seatbelt when it is able to fit properly and snugly across the upper thighs (not the stomach), and lie snugly across the shoulder and chest (not across the neck or face). The child should still remain in the back seat.

Children should be kept in the car seat for as long as possible, while he or she remains in range of the manufacturer's maximum height and weight limits.

It is important to know that car seats and booster seats can't be used forever. Please pay attention to the manufacturer's expiration dates on your car seat. New car seats should be purchased if an expiration date has passed, regardless if the child has yet to outgrow that particular seat.

Remember, always keep your child in the back seat through at least age 12.

For more information on car seat guidelines and how to keep your child safe during travel, visit www.nhtsa.gov

Teaching Your Teen to Be a Safe Driver

There are few things teenagers look forward to more than turning 15 and getting their learner's permit (and there are probably few things parents dread more). It is a very exciting time that allows for new independence, but it also requires maturity and acceptance of the responsibility that comes with driving. According to a Florida DMV report, in 2009 Florida teens had 29,482 car crashes resulting in 153 deaths. So how can you keep your child safe while guiding them through this exciting chapter?

Allow your child to get his learner's permit as soon as possible and pack in as much supervised driving experience as you can. Provide practice driving under a wide range of conditions (sunny afternoons, at night, when it's raining) and settings (neighborhood roads, busy intersections, highways). Research has shown, pretty conclusively, that the way new drivers become better is by gaining driving experience. Somewhat surprisingly, the research says that, after the initial period of being taught to drive by parents, it is the teenager driving alone, which gives the experience he needs to become a safer and more competent driver.

One of the best ways to keep your child safe once he is driving alone is to develop and enforce a written contract. A contract clearly states the driving rules and privileges as well as the consequences for breaking them. Your teenager will agree to each of the terms, understand exactly what is expected of him, and will have no argument when a punishment is enforced. When you reach an agreement, sign the document and provide a copy to your teenager. Set a date to review and revise the agreement after a designated period in order to relax the agreement somewhat if your teenager has done well with his driving. If any rules are broken and you need to pull your child's independent driving privilege, encourage—even require—him to continue to drive with you in the car for more experience.

Some key points to include in your contract are listed below, as well as a link to two great sample contracts you can print and complete (even if your child already has his license—it's never too late).

- Require seat belt use for the driver and all passengers in the vehicle.
- Restrict extra passengers, especially early on. This is particularly important because the risk of an accident goes up sharply with young drivers carrying passengers.
- Do not allow your child to ride with a new driver. The rules you creates help decrease your child's chance of an accident, but the passengers of other teen drivers are still at risk.
- Take a hard line about alcohol (and drug) use and driving.
- Don't permit any texting or cell phone use when the car is moving. Eating, changing music, and using the GPS are other common distractions. Each day, more than 15 people are killed and more than 1,200 people are injured in crashes that are reported by a distracted driver.

http://sites.google.com/site/parentingteendriverd2/Home/our-contract
http://www.cdc.gov/Motorvehiclesafety/pdf/Driving_Contract-a.pdf

MIDDLETON PEDIATRICS

Motion Sickness

There once was a man from Nantucket,
Who at sea always carried a bucket.
Whenever asked why,
He replied with a sigh,
'I never know when I'll upchuck it'

Your face is feeling flushed. Perhaps a headache. Suddenly you feel very tired. You are sweating despite the fact that you are not doing any exercise. The saliva in your mouth starts feeling thicker. And then comes the nausea…

Anyone who has experienced a full-blown episode of motion sickness will agree that it is both unforgettable and close to the height of misery. In this article, we hope to shed a little light on motion sickness, why it occurs, and what you can do to prevent it.

BACKGROUND

Motion sickness has been reported and written about for thousands of years, probably becoming more widespread with the advent of boat travel. The ancient Greek physician Hippocrates described the typical symptoms. Julius Caesar (and his horses!) famously suffered from it and would allow a day or two of recovery after a voyage before attacking their enemies.

For most of history, seasickness has been the type of motion sickness most commonly experienced; in fact, the term "nausea" comes from the Greek word "naus" which means "sea" (e.g. nautical, navy). Only later did nausea become broader in its meaning to include other causes of vomiting. With the development of other forms of travel such as automobiles and airplanes, the more general term "motion sickness" has been popularized.

WHY IT OCCURS

It is actually quite remarkable that despite motion sickness having been recognized for such a long time, our understanding of it is still quite limited. Motion sickness can probably best be thought of as a form of severe dizziness as opposed to an illness. Everyone is susceptible to experiencing motion sickness if the situation is severe enough, though obviously there is great variability in how sensitive one is to developing it.

Our sense of balance is the result of our brain receiving input from three primary sources:

- Our eyes
- Our inner ears
- Our "proprioceptors" throughout our body

The brain is trying to use this input to estimate how much the head is moving. Current understanding believes that motion sickness occurs when the brain receives conflicting messages from these sources. It is interesting that when one's movement is self-directed, the brain is great at rendering a "stable" position and motion sickness is extremely unlikely. Activities such as dancing vigorously, playing basketball, even jumping rope, are examples. However, if the movement is not self-directed but rather is passive (happening TO you as opposed to BY you), one is more vulnerable to becoming nauseated. This seems to be because the brain is getting different signals—e.g. the eyes see "stationary" objects inside of car or cabin, but the inner ears are detecting movement.

For infants, it is virtually impossible to get motion sick. The incidence increases during childhood, peaking at approximately 12 years old. Individuals with a tendency to get migraines are more susceptible to motion sickness as are pregnant women. Expectations also play a major role -- if you think you are going to get motion sickness, you probably will.

"GETTING YOUR SEA LEGS" — WHAT CAN I DO ABOUT IT

When motion sickness occurs, it will go away… eventually. Experience and research suggests that the symptoms will subside after 1-3 days of continuous exposure to the stimuli (but that can certainly make for a long 1-3 days). Obviously it may then recur with a subsequent exposure, but this likelihood does go down with repeated exposure.

Some treatment measures do exist for motion sickness; however, like so many things in medicine, prevention tends to be far better than treatment. Where you sit in the vessel helps: sitting in the front seat of a car, near the wing of a plane, and near the center of the ship's hull all make it less likely that one will develop motion sickness. Additionally, focusing on an "earth-fixed" object (as opposed to something that is moving right along with you) will help. An example of this is the old adage "focus on the horizon" when on a boat. This allows the movement sensed by your ears to be in agreement with what your eyes detect. The opposite effect is seen if you are reading a book in a car or on a boat; focusing on an object such as this that is moving right along with you will make motion sickness more likely. Positional measures such as lying down on your back can also be helpful.

Certain medications have been shown to be somewhat effective for motion sickness. Antihistamines are the most commonly used medicines and these include dramamine, antivert, and Benadryl. Nonsedating anthistamines such as Claritin and Zyrtec do not tend to be of any benefit. Scopolamine is an anticholinergic medication that is effective at preventing motion sickness and is typically given in the form of a patch. This medicine is available only with a prescription. Other treatments such as caffeine and ginger have some possible benefit, but results are not consistent. Acupressure ("Acubands") and magnets are other treatment modalities often used, and their effectiveness is debatable.

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CARING WELL

Middleton Pediatrics would like to invite you to an evening discussion on "Asthma and Your Child" on Thursday, May 3rd. Dr. Middleton will be conducting the time from 6:00pm to 7:30pm, and will be joined by Dr. Weatherly, a pediatric pulmonologist from Arnold Palmer Hospital, and Heather Staples, a medical student at Florida State University.

This is the seventh discussion in a series of talks entitled "CARING WELL-A Curriculum for parenting and pediatric health that goes beyond simply not being sick".

Topics will include:

-How to know if your child has asthma

-What does the latest research show regarding why asthma occurs

-How can I help to best manage my child's asthma

Space is fairly limited, so if you are interested, please respond to our Family Care Coordinator, Kelli Coon, at kelli@middletonpediatrics.com or (407) 284-6460

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