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FOOTNOTES

[1] Age: newborn-red reflex; Age 6-12 months –red reflex, fix and follow, alternate occlusion

[2] At Risk=Persons at risk for recent latent tuberculosis infection with clinical conditions that increase the risk for TB, regardless of age. Testing is discouraged among persons of low risk.

[3] Injecting drug users, recipients of clotting factor concentrates made before 1987, long term hemodialysis patients, recipients of blood and/or solid organs before July 1992, infants born to infected mothers, and healthcare/public safety workers only needle sticks, sharps or mucosal exposures to HCV-positive blood.

[4] For a complete listing of safety and injury prevention topics, see www.brightfutures.com.org

[5] Timing of vaccine: 2nd dose at least 1 month after the 1st dose; 3rd dose at least at least 4 months after the 1st dose and 2 months after the 2nd dose. Children of HbsAg-positive mothers should also receive HBIG within 12 hours of birth.

[6] The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose should be give at ≥ 4 years.

[7] Acceptable Poliovirus immunization schedule: 2, 4, 6-18 months and 4-6 years of age.

[8] The second dose of MMR is recommended routinely at 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered beginning, at, or after age 12 months. Those who have not previously received the second dose should complete the schedule by age 11-12 years.

[9] Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. The final dose of the series should be administered at age ≥ 12 months.

[10] Varicella vaccine is recommended at any visit at or after age 12 months for those who lack evidence of immunity . ACIP now recommends that all other persons aged ≥ 13 years without evidence of immunity be vaccinated with 2 doses of varicella vaccine 4-8 weeks apart. See www.cdc.gov/nip/vaccine/varicella/varicella_acip_recs.pdf. For a revised definition for evidence of immunity to Varicella.

[11] The heptavalent Pneumococcal conjugate vaccine (PCV) is recommended for all children aged 2-23 months and for certain children aged 24-59 months (i.e. children with sickle cell disease and other sickle cell hemooglobinopathies, congenital or acquired asplenia or splenic dysfunction, and conditions associated with congential immunodeficiency's such as chronic renal failure, nephrotic syndrome, lymphoma, and HIV along with conditions such as chronic heart disease or chronic lung disease and diabetes mellitus. The final dose of the series should be given at ≥12 months. The Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high risk groups.

[12] Influenza vaccine is recommended annually for children aged 24-59 months and their household contacts and their out-of –home caregivers. Also children aged 6 months to <9 years of age, who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks for TIV (trivalent inactivated influenza vaccine) and at least 6 weeks for the LAIV (live, attenuated influenza vaccine)

[13] Per current AAP recommendations-Palivizumab or RSV-IVIG prophylaxis should be considered for infants and children younger than two years of age with chronic lung disease who have required medical therapy (i.e. supplemental oxygen bronchodilator, diuretic or corticosteroid therapy) within six months before the start of RSV season. Infants born at 32 weeks of gestation or earlier may benefit from RSV prophylaxis even if they do not have chronic lung disease. For infants, major risks factors to consider include their gestational and chronological age at the start of the RSV season. Once a child qualifies for the initiation of prophylaxis, administration should continue throughout the season and not stop until the child is six or 12 months of age.

[14] Meningococcal vaccine (MCV4) should be given to all children in the 11-12 year old visit as well as to unvaccinated adolescents at high school entry (15 years of age). Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥ 2 years of age with terminal complement deficiencies or anatomic of functional asplenia and certain other high risk groups. Use MPSV4 meningococcla polysaccharide vaccine) for children aged 2-10 years and MCV4 (meningococcal conjugate vaccine) although MPSV4 is an acceptable alternative.

[15] Per AAP's Health Supervison Recommendations- BMI should be calculated and plotted once a year in all children and adolescents. Change in BMI should be used to identify rate of excessive weight gain relative to

linear growth. For adult patients with a BMI of 25-34.9, sex-specific waist circumference cutoffs should be used in conjunction with BMI to identify increased disease risks. If the patient is overweight (BMI 25+) then as a very general rule, an unhealthy waist circumference is above 35 inches (women) or above 40 inches (men)

[16] One cholesterol measurement is recommended between two and 19 years for children who have a known primary relative with hyperlipidemia.

[17] At risk for: Gonorrhea and Chlamydia=sexually active women under 25 with other STD's, multiple partners or those not using condoms consistently and /or correctly. Syphilis=History of STD, individuals who exchange sex for money or drugs, contacts with people who have syphilis. HIV=History of STD, male/male sexual activity , current or prior IVDU, current or former sex partner recently HIV + or at risk, history of transfusion between 1978 and 1985. All pregnant women and individuals having unprotected sex with multiple sex partners.

[18] The ACIP recommends that girls receive the HPV vaccine when they are 11-12 years old and also allows for vaccination of girls beginning at nine years old as well as vaccination of girls and women 13-26 years old.

[19] Initial cholesterol and HDL screen for men and women 20 and older if other risk factors for CAD exist. Initial screening for all men age 35 and older and women age 45 and older, only if positive risk factor and to be repeated every 5 years thereafter, unless test results or clinical indicators suggest otherwise.

[20] The USPSTF recommends screening for Type 2 Diabetes in adults with hypertension or hyperlipidemia.

[21] Risk for Hepatitis A=Living or traveling to areas of intermediate of high endemicity, male/male sexual activity, IVDU, chronic liver disease.

[22] Annual fecal occult blood test, sigmoidoscopy every 3-5 years, or colonoscopy every 10 years.

[23] It is the expectation that this discussion occurs and is documented for those ages $\geq$ 40. See www.health.ri.gov for further information.

[24] A single dose of Tdap should be given routinely to adolescents 11-12 years of age who have completed the recommended childhood DTP/DTaP vaccination series and have not received a Td booster dose. As vaccine supply permits, Tdap may also be given to adolescents 13-18 years of age. An interval of at least 5 years between Td and Tdap is encouraged to reduce the risk for local and systemic reactions after Tdap vaccinations.