IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION
CIVIL ACTION NO. 11-CV-22026-MGC

**DR. BERND WOLLSCHLAEGER,** et al.

Plaintiffs,

v.

**RICK SCOTT,**
*In his official capacity as Governor of the State of Florida,* et al.

Defendants.

**DECLARATION OF DR. LISA COSGROVE**

I, Dr. Lisa Cosgrove, do hereby declare as follows:

1. My name is Dr. Lisa Cosgrove, and I am a member and the President of the Florida Chapter of the American Academy of Pediatrics ("FAAP"), a plaintiff in the above-captioned matter.

2. FAAP is a nonprofit Florida corporation, which serves as the Florida chapter of the national American Academy of Pediatrics ("AAP") organization. The mission of FAAP is to promote the health and welfare of Florida's children, including newborns, infants, children, adolescents and young adults, and to support pediatricians and pediatric specialists in providing quality healthcare to this group of patients.

3. As of June 2, 2011, FAAP has 1,682 members. Members include medical students, residents, and fully licensed doctors and dentists who have either studied or practiced

pediatric medicine. FAAP members reside and work in all major cities and geographic regions of Florida, with the highest concentration in Miami-Dade County. FAAP offers various levels of membership status, including Fellows, Associate Members, Young Physicians, Emeritus Fellows, Honorary Members, Resident Members, Medical Student Members, and Military Members, corresponding to the career status of its member physicians. In order to belong to FAAP, members must pay annual dues that vary according to membership level, with annual full dues currently set at $200 in addition to AAP national dues. Members of FAAP vote to elect FAAP's Executive Committee including its President, President-Elect, Immediate Past President, Secretary and Treasurer, as well as FAAP's Board of Directors. Only certain types of FAAP members are eligible to hold office. Attached as Exhibit 1 is a true and correct copy of FAAP's Constitution and Bylaws.

4. FAAP provides important services to its Florida members such as advocating specific local or regional Florida issues, bringing those issues to national attention as necessary, hosting local seminars, discussion groups, and meetings in Florida, and providing members with practice updates, newsletters, and organizational updates specific to Florida. As President of FAAP, I work with FAAP's Executive Committee to provide leadership and governance, and FAAP's standing committees such as the Committee on Finance, the Committee on Continuing Medical Education, and the Committee on Practice Support take a lead role in organizing other specific organizational services.

5. FAAP also works closely with its national-level affiliate, the American Academy of Pediatrics ("AAP"), a national organization comprising more than 60,000 pediatricians. The AAP and its chapters have a unique partnership of autonomy and cooperation. They are required to maintain bylaws and see that these bylaws do not conflict with the Academy's bylaws, and are

required to elect officers (President and Vice President) that are voting members of the national Academy. Chapters have complete organizational control over their activities, allowing them the freedom to address the needs and interests of their individual members.

6. AAP and its member pediatricians dedicate their efforts and resources to the health, safety and well-being of infants, children, adolescents, and young adults. AAP has approximately 60,000 members in the United States, Canada, Mexico, and many other countries. Members include pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.

7. Both AAP and FAAP further the professional education of their members through meetings, seminars, and publications. In addition, AAP produces patient brochures containing safety guidance adopted by both AAP and FAAP that are available to FAAP members to distribute to their patients. Both AAP and FAAP also engage in advocacy, promoting the interests of their members and their organizational mission.

8. FAAP's goals include increasing its voice and influence on behalf of both children and pediatricians, promoting the art and science of pediatrics, encouraging young physicians to specialize in pediatrics, uniting qualified pediatricians in Florida, and addressing the changing needs and interests of pediatricians.

9. In support of FAAP's goal of increasing the quality of medical care available to the children of Florida and promoting the art and science of Pediatrics, FAAP together with its parent organization AAP publishes, promotes, and disseminates practice guidelines, policy statements, and academic literature relating to best practices in pediatric medicine.

10. AAP and FAAP, as its Florida chapter, recommend that pediatricians provide counseling and anticipatory guidance regarding the prevention of unintentional and intentional

injury as part of their preventive healthcare services. AAP and FAAP believe that pediatricians play a key role in educating parents about the risks of unintentional injuries and suggesting specific measures to minimize those risks, including environmental modification or the use of safety equipment. AAP and FAAP advise pediatricians that anticipatory guidance is a major component of well-child care and injury visits, and that anticipatory guidance for injury prevention should be an integral part of the medical care provided for all infants, children, and adolescents.

11. AAP and FAAP recommend that pediatricians implement preventive care practices such as counseling patients on effective methods for minimizing a variety of health and safety risks. To promote appropriate preventive counseling practices, AAP together with its subchapters, including FAAP, organized and implemented an initiative beginning in 1983 called The Injury Prevention Program ("TIPP"). TIPP includes a safety-counseling schedule for physicians, age-appropriate safety surveys, and age-appropriate safety sheets for physicians to distribute to patients and their families. Attached as Exhibit 2 is a true and correct copy of an example of physician literature regarding injury prevention published by AAP as part of TIPP.

12. Another initiative supported by AAP and FAAP called Bright Futures similarly encourages physicians to provide a wide range of injury prevention counseling and other preventive practices, and includes guidelines and literature aimed at both physicians and their patients. The injury prevention counseling recommended as part of the Bright Futures guidelines echoes that provided through the TIPP program.

13. Preventive consultations are particularly important in a pediatrician's medical practice because of the dangers to which infants, children, and young adults are disproportionately at risk. Through TIPP, Bright Futures, and related materials, AAP and FAAP

recommend counseling patients and families on matters including household chemicals, swimming pools, bike helmets, automotive safety seats, and firearms safety.

14. As set forth in the Bright Futures literature, unintentional injury occurring from many causes—including firearms—is the leading cause of death and morbidity among children older than 1 year, adolescents, and young adults. *Promoting Safety and Injury Prevention*, Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, http://brightfutures.aap.org/pdfs/Guidelines_PDF/10-Promoting_Safety_and_Injury_Prevention.pdf (last visited June 8, 2011) (hereinafter, "Bright Futures Guidelines"). Firearms in particular pose risks in households with children. One third of U.S. homes with children younger than eighteen have a firearm. Johnson, Renee M., MPH, Tamera Coyne-Beasley, MD, MPH, and Carol W. Runyan, Ph.D. "Firearm Ownership and Storage Practices, U.S. Households, 1992-2002." *American Journal of Preventive Medicine* 27 (2004): 173-82, 179. In addition, more than 40 percent of gun-owning households with children store their guns unlocked and one quarter of those homes store them loaded. *Id.* According to the most recent data sets published by the Centers for Disease Control and Prevention, every day in America 38 children and teens are injured by firearms, and 8 are killed by firearms. *WISQARS Nonfatal Injury Reports*, National Center for Injury Prevention and Control, http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html (report last accessed on June 16, 2011); *WISQARS Injury Mortality Reports, 1999 – 2007*, National Center for Injury Prevention and Control, http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html (report last accessed on June 16, 2011). Children and families in Florida face particular risk of gun violence, as Florida's overall gun death rate exceeds the national average. *National Vital Statistics Reports*, U.S. Department of Health and Human Services, http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_19.pdf (last visited June 8, 2011). From 1999 to 2007,

1,195 children and teens in Florida were shot and killed with firearms. *WISQARS Injury Mortality Reports, 1999 2007*, National Center for Injury Prevention and Control, http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html (report last accessed June 8, 2011).

15. Suicide prevention is another reason why firearm safety counseling is an important part of our members' preventive consultations. Studies have shown that the presence of a firearm at home increases the risk of suicide even among those children and adolescents without a previous psychiatric diagnosis. D.A. Brent, J.A. Perper, et al., *Firearms and Adolescent Suicide: A Community Case-Control Study*, 147 Am. J. Dis. Child 1066 (Oct. 1993).

16. Physician safety counseling practices such as those outlined in programs supported by AAP and FAAP including TIPP and Bright Futures have been shown to be effective in improving parental safety practices. Robert H. DuRant, Shari Barkin, et al., *Firearm Ownership and Storage Patterns Among Families with Children Who Receive Well-Child Care in Pediatric Offices*, 119 Pediatrics 1271 (2007). In turn, parental safety practices are associated with lower risk of suicide and unintentional shootings in children and adolescents. David C. Grossman, Beth A. Mueller, et al., *Gun Storage Practices and Risk of Youth Suicide and Unintentional Firearm Injuries*, 293 JAMA 707 (2005). For example, a review of the literature on childhood injury-prevention counseling in primary care settings demonstrated that 18 of 20 studies have shown positive outcomes in increasing knowledge and behavior and in decreasing injury rates in children. This research has appeared in *Pediatrics*, a monthly peer-reviewed academic journal published by AAP. Attached as Exhibit 3 is a true and correct copy of an article published in *Pediatrics* that addresses firearms safety counseling recommendations specifically, and the proven effectiveness of such safety counseling generally.

17. AAP's and FAAP's injury prevention counseling research and recommendations can also be found in *AAP's Textbook of Pediatric Care*, a textbook published by AAP to help educate practitioners. Attached as Exhibits 4 is an excerpt from this textbook regarding firearms safety counseling guidance.

18. AAP and FAAP specifically urge practitioners to ask parents about firearm ownership and inform parents about the dangers of firearms in and outside the home. AAP and FAAP recommend that pediatricians incorporate questions about firearms into the patient history process and support the education of physicians and other professionals to increase understanding of the effects of firearms and help reduce the morbidity and mortality associated with their use.

19. In particular, AAP and FAAP make the following specific recommendations to physicians regarding firearms safety counseling:

a. In infancy and early childhood, pediatricians are encouraged to counsel on firearms safety in the context of home safety and safe storage of other hazardous items such as medications or cleaning supplies.

b. In early and middle childhood, this message can be built upon by encouraging parents to ask about the presence of firearms in homes where their children play; it should be emphasized that young children simply do not understand how dangerous firearms are and cannot be taught to overcome their curiosity about firearms.

c. Counseling on firearms injury prevention should be directed solely to parents through the 5 and 6 year visits; beginning with the 7 and 8 year visits,

pediatricians can counsel children not to touch firearms and to tell a parent if they see a gun.

d. In adolescence, youth should be asked about fighting and weapon carrying and counseled on nonviolent approaches to conflict resolution.

e. Pediatricians should talk to parents about the risk posed by keeping firearms in homes where teens live. Firearms are used in a majority of adolescent suicides, and over 90% of suicide attempts involving a firearm are fatal. Because teens can be very spontaneous and most teens have at least brief periods of depression, keeping a firearm in the home—even if it is unloaded and locked up—can be very dangerous for adolescents. For adolescents at risk of suicide, parents should be urged to remove firearms and ammunition from the home.

20. As one FAAP member physician recently explained, questions about firearms in the home are merely one part of a larger discussion about potential hazards in the home, a discussion that includes such topics as water temperature, access to pools, and the type of dog parents may own. "These [other] questions are just as personal as whether my patients' families own a gun," she said. "Physicians take care of toddlers who are accidently burned by water that is too hot in the bathtub. We feel the gut-wrenching pain when a child who has a drowned is transported into the ER." She explained asking about gun ownership enables her to "find out whether I need to provide suggestions for improved safety in the home."

21. Another pediatrician, a "proud" gun owner himself, echoed such sentiments. "Asking whether firearms are in a child's environment is as vital a piece of information in my risk assessment as knowing whether there are alcoholics in the homes, drug abusers, presence of trampolines, or any number of things that could harm a child," he said.

22. FAAP has already received feedback from a number of its members regarding H.B. 155 (the "Physician Gag Law" or the "Law") and its effect on their practices as well as their patients. FAAP member pediatricians have made known to the organization their opposition to the Physician Gag Law, their belief in the value of preventive medicine, and their fear that the law will suppress the free exchange of information and advice between doctors and patients that is necessary to provide effective care.

23. One member wrote to FAAP to express her concerns about the Law's detrimental effects, saying, "I ask about a lot of safety issues when I perform a well child check-up, discussing eliminating a child's access to harmful household dangers including pools, poisons, guns, matches, etc. If I cannot ask about these items in the home, how can I know if the parent is informed enough to keep their child safe? . . . . The patient-physician relationship is a vital part of our role as Pediatricians, and having restrictions placed on what we can and cannot discuss by those who do not practice medicine is simply unbelievable, not to mention horrifying."

24. Another member physician discussed the effect that the law would have on doctors in training, stating "certainly our residents will be hesitant to jeopardize their budding careers in view of the potential penalties for trying to protect their patients for which they all have sworn an oath of responsibility as physicians."

25. As another FAAP physician emphasized, the bottom line is that the Physician Gag Law will harm patients because it restricts physicians' most effective means of counseling – an interactive dialogue with patients. "I suppose my counseling with patients will be impersonal and vague, vanilla statements, such as 'if there are firearms in the house, they should be locked up and out of reach,' rather than a problem solving dialogue which patients have come to expect and we prefer because it leads to better outcomes."

26. In fact, FAAP physicians began experiencing harm caused by the Physician Gag Law even before it became law. As one explained, "[w]e have already felt an impact as some patients have threatened us saying we don't have the right to ask. I guess they believe the law is signed. We are no longer asking or stating anything about firearms as I don't want to get sued."

27. As a physician and gun owner myself, I agree with FAAP's members that the Physician Gag Law will adversely affect the quality of care that I and other physicians are able to give our patients. In my practice, I find that patients are generally appreciative of discussions I have with them regarding gun safety, including the fact that I can provide them with free gun safety locks if necessary. However, now that the Law has passed, I ask parents or patients permission to talk about guns, and if the parent or patient exhibits reluctance to discuss the subject, I no longer ask about guns in order to avoid the potentially dire professional consequences the Law would impose on me should the patient accuse me of violating it. For example, before the Law was passed, I used to ask children aged six to seven years old what they would do if they saw a gun on the ground. Now that the Law is in effect, however, I ask for parental permission before asking that question; if the parent does not give permission, I do not ask.

28. The combination of vague restrictions and dire consequences imposed by the Physician Gag Law has caused physicians like myself to self-censor our speech to patients on this important safety issue. On top of the Law's intrusion into the doctor-patient relationship, the Law is not clear about the circumstances under which a physician may be allowed ask patients or families about guns and what physicians can record regarding the discussion. As a result, physicians are at a loss to determine how to effectively counsel patients without risk of violating the Law. Physicians cannot afford to take lightly the possibility that, by simply asking patients

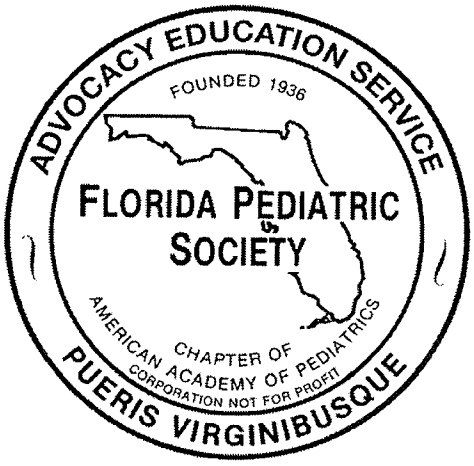
gun safety related questions, they may face disciplinary proceedings before the Florida Board of Medicine, which can result in revocation of one's license and fines. These consequences can be devastating for physicians both personally and professionally by harming their reputations and their ability to practice medicine. As a result, the Physician Gag Law will cause many physicians to cease advising patients on the health risks associated with firearms altogether, and may cause others to provide less detailed, compelling, or helpful guidance. This will directly harm patients and families who will be deprived of vital safety counseling.

I declare under penalty of perjury that the foregoing is true and correct.

Dr. Lisa Cosgrove

Executed on June 20, 2011

# COSGROVE EXHIBIT 1




# CONSTITUTION AND BYLAWS

# The Florida Pediatric Society/ The Florida Chapter of the American Academy of Pediatrics

Revised 5/8/10

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# CONSTITUTION

# OF THE FLORIDA PEDIATRIC SOCIETY/THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

## ARTICLE I

The name of this Corporation shall be The Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics (FPS/FCAAP). The principal office and place of business shall be Tallahassee, Florida, until otherwise established and ordered by the Board of Directors. The business of this Corporation shall be carried on at Tallahassee, Florida, and at such other places as may be authorized by the Board of Directors.

## ARTICLE II

Vision: Improve the health and welfare of Florida's children

Mission: Improve access to, and the quality of, health care for infants, children, and young adults in Florida and insure the stability, continuity and effectiveness of the Chapter

Goals:
- Increase FPS/FCAAP voice and influence on behalf of children and pediatricians
- Promote the art and science of pediatrics
- Encourage young physicians to specialize in pediatrics
- Unite qualified pediatricians in Florida
- Demonstrate the value of FPS/FCAAP to members and potential members
- Address changing needs/interests of pediatricians
- Maintain current responsive by-laws, committees, and regions for the Chapter
- Identify and implement stable non-dues revenue to support FPS/FCAAP mission
- Maintain involvement of seasoned leaders and encourage young leaders

## ARTICLE III

The members of the Corporation shall be those persons who are now members of the organization; and in addition such other persons shall be members as are elected to membership by the members in accordance with the Bylaws. The categories of membership in the Corporation shall be provided for in the Bylaws and may be changed by appropriate amendment of the Bylaws.

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## ARTICLE IV

This Corporation shall have perpetual existence.

## ARTICLE V

The affairs of the Corporation shall be managed by a Board of Directors as defined in the Bylaws.

a) To establish one or more offices and to employ such agents, an Executive Director, employees, and clerical force as may be deemed necessary or proper to conduct and carry on the work of the Corporation and to pay a reasonable compensation for the services of such persons.
b) To contract and be contracted with, sue and be sued, invest and reinvest the funds of the Corporation, and to do all the acts and things requisite, necessary, proper or desirable to carry out and further the objects for which this Corporation is formed.

## ARTICLE VI

This organization may not own or hold any real estate.

## ARTICLE VII

No part of the assets or income of the Corporation shall inure to the benefit of any member of the Corporation or individual. No officer or director of this Corporation shall receive directly or indirectly any compensation for services as such officer or director; however an Executive Vice-President may be appointed with such compensation as may be fixed by the Board of Directors. Membership in this organization shall be considered a privilege and not a right. Add statements referring to FPS Policies of General (in addition to Medical Ethics), Antitrust, and Conflict of Interest.

Revised 5/8/10

# BYLAWS

# OF THE FLORIDA PEDIATRIC SOCIETY/THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

## CHAPTER 1 - MEMBERS

1.01 The categories of membership in this organization are: Fellows, Associate Members, Emeritus Fellows, Honorary Members, Young Physicians, Resident Members, Medical Student Members, Military Members and Chapter Affiliate Members.

1.02 Fellow: A person is qualified for membership as a Fellow who is Pediatrician or Pediatric Specialist practicing in the state of Florida. Fellows shall have the right to attend and vote in the deliberations of all regular and special meetings of the organization. Fellows shall be eligible for election to all offices. Members of the American Academy of Pediatrics who are classified as Fellows, Candidate Members, Specialty Fellows or Post-Residency Training Fellows shall be considered Fellows of this organization. Fellows shall pay all dues and assessments.

1.03 Associate Member: An Associate Member shall be a physician who desires membership, practices in the state of Florida and has a special interest in the care of children; or a pediatric dentist who has received a certificate or a degree in the specialty of pediatric dentistry recognized by the Council on Accreditation of the American Dental Association or its equivalent and who is licensed to practice dentistry in the state of Florida. Associate Members shall not be entitled to vote, and shall not be eligible for office. Members of the American Academy of Pediatrics who are classified as Associate Members shall be considered Associate Members of this organization. Associate Members shall be required to pay initiation fees, if applicable, and annual membership dues.

1.04 Young Physician: A person is qualified for membership as a Young Physician who is younger than 30 years of age, and a Pediatrician or Pediatric Specialist practicing in the state of Florida. Young Physicians shall have the right to attend and vote in the deliberations of all regular and special meetings of the organization. Young Physicians shall be eligible for election to all offices. Members of the American Academy of Pediatrics who are classified as Young Physicians shall be considered Young Physicians of this organization. Young Physician shall pay one-half of all dues and assessments.

1.05 Emeritus Fellow: Any Fellow in good standing who has reached the age of 70 years shall be granted Emeritus status by applying in writing to the Executive Director. Emeritus status is also granted to Fellows at any age for reasons of exigencies of health or other circumstances. Such requests are to be approved by the Board of Directors. An Emeritus Fellow may not vote or hold office, and shall not be required to pay dues or assessments. Members of the American Academy of Pediatrics who are classified as Emeritus Fellows shall be considered Emeritus Fellows of this organization.

1.05 Honorary Member: An Honorary Member of this organization shall be a physician of eminence in pediatrics, or any person who has made distinguished contributions or has rendered distinguished service to medicine, primarily in the field of pediatrics. Honorary Members shall not be required to pay fees or dues. Members of the American Academy of Pediatrics who are classified as Honorary Fellows shall be considered Honorary Members of this organization. Honorary Members shall be subject to final approval for such membership by the Board of Directors and the general membership.

1.06 Resident Member: Resident Members must be enrolled in a pediatric residency training program that is an Accreditation Council for Graduate Medical Education (ACGME) approved program. Resident Members shall have the right to attend all regular and special meetings of the organization. Resident Members shall not vote or hold office. Members of the American Academy of Pediatrics who are classified as Resident Members shall be considered Resident Members of this organization. The Board of Directors shall decide the dues for Resident Members.

1.07 Medical Student Members: Medical Student Members shall have indicated an interest in child health advocacy and be considering a career choice in pediatrics and be currently enrolled in a medical school accredited by the Association of American Medical Colleges (AAMC.) Applicants shall submit an application with a signature from one sponsor, preferably a pediatric educational program director or chairperson, who must be a Chapter Affiliate or Fellow of the organization. Medical Student Members shall have the right to attend all regular and special meetings of the organization. Medical Student Members shall not vote or hold office. The Board of Directors shall decide the dues for Medical Student Members.

1.08 Military Member: A person is qualified for membership as a Military Member who is a Doctor of Medicine and who is on active duty with the Armed Forces of

the United States of America. Military Members shall have the right to attend and vote in the deliberations of all regular and special meetings of the organization. Military Members shall be eligible for election to all offices. Military Members shall pay all dues and assessments.

1.09 Chapter Affiliate Members: Chapter Affiliate Members shall include any members who do not fit into any of the other categories outlined above. The Board of Directors shall decide the dues for Chapter Affiliate Members.

1.10 Any existing member of the American Academy of Pediatrics who resides in Florida may become a member, and shall be placed in the corresponding category as outlined above.

1.11 Any member who moves outside the State may, if so requested, be granted a leave of absence by the Board of Directors. During such leave of absence, said member may neither vote nor hold office, and shall be exempt from the payment of dues.

1.12 Any member found guilty in a court of law of a felony, an offense involving moral turpitude, or who is guilty of conduct unbecoming a member, may be expelled from membership by the Board of Directors.

## CHAPTER 2 - ASSESSMENTS

2.01 The amount of the annual assessment for members shall be determined by the Board of Directors after consideration of the annual budget for the next year and shall be announced to the membership not less than one month before the due date of the assessment.

2.02 Special assessments may be levied on the members when and as determined by the Board of Directors to defray any extraordinary expenses that may be incurred by the organization.

2.03 The Executive Committee may, during unusual circumstances, such as illness or extreme hardship, suspend assessments of any member, subject to annual review.

## CHAPTER 3 - REGULAR AND SPECIAL SESSIONS

3.01 The organization shall hold one or more sessions each year.

3.02 The regular annual session shall be held at a time and place selected by the Board of Directors.

3.03 The regular annual session shall be known as the Annual Meeting and shall include both a scientific program, provided by the Continuing Education Committee, and an Annual Business Meeting to transact any and all business that shall come before the members. There shall be a regular session to conduct any and all business

3.04 All resolutions and items for consideration by the entire membership shall be submitted in writing to the Executive Committee no later than thirty days prior to the start of the Annual Business Meeting. All resolutions shall be presented in the format required by the Annual Leadership Forum of the American Academy of Pediatrics.

3.05 The members present and voting shall constitute a quorum at the annual business meeting.

## CHAPTER 4 - BOARD OF DIRECTORS

4.01 The Executive Committee of the Board of Directors shall be composed of the following:

a) President,
b) President-Elect,
c) Immediate Past President,
d) Secretary, and
e) Treasurer.

4.02 The governing members of the Board of Directors shall be composed of the following:

f) President,
g) President-Elect,
h) Immediate Past President,
i) Secretary,
j) Treasurer,
k) One Regional Representative for each Region,
l) One Alternate Regional Representative for each Region,

m) One At Large delegate or one delegate representing the Chairmen of the Departments of Pediatrics of each medical school in Florida, and

n) One delegate representing the Directors of the Pediatric Residency Programs in Florida.

o) The Editor of the approved organization publication(s).

4.03 The appointed *ex officio* members of the Board of Directors shall be composed of the following:

p) Chairmen of the Departments of Pediatrics of each medical school in Florida,

q) The Child Advocate Member,

r) Directors of the Pediatric Residency Programs in Florida,

s) Director of the Children's Medical Services,

t) The Resident Section Member,

u) Chairs of all Standing Councils/Committees,

v) A representative of Florida's children's hospitals, and

w) Any others as recommended by the President and approved by the Board of Directors.

4.04 The President shall identify individuals to serve in the appointed positions on the Board of Directors as one of the first duties upon assuming office.

4.05 All members of the Board of Directors except the Regional Representatives and Alternate Regional Representatives shall serve for two years, coincident with the term of the President. Regional Representatives and Alternate Regional Representatives shall serve a two year term from the time of their election. Four regions shall have elections on even and odd years.

4.06 Any votes pertaining to fiscal or governance matters must be submitted to the Executive Committee. A vote must be placed by a majority of the governing members of the Executive Committee for that vote to be valid.

4.07 Any votes not pertaining to fiscal or governance matters are submitted to the members of the Board of Directors present at a given meeting. A simple majority vote of those present shall decide the matter.

4.08 The Board of Directors shall meet at the call of the President or upon written request of four members of the Board of Directors. Thirty days notice shall be provided for face-to-face meetings of the Board. Meetings offered in other formats shall be announced with sufficient notice.

4.09 Members of the Board of Directors shall attend a minimum of fifty percent (50%) of the called for Board meetings. Failure to do so may result in the Executive Committee replacing the member.

4.10 The Board of Directors shall consider all matters referred to it by the Judicial Committee and shall determine any disciplinary action to be taken.

4.11 The Board of Directors shall have the power from time to time to create Task Forces from its number and to endow them with authority to act in the interim between meetings of the membership and of the Board of Directors. These may be augmented by appointment of additional members who are not members of the Board of Directors. The Board of Directors from time to time will review each Task Force for relevancy and shall have the option to create a new Task Force or sunset a Task Force at will.

4.12 The Board of Directors has the power to inspect and audit any accounts pertaining to the organization. The Board of Directors shall also see that annual reports are made on all matters pertaining to the finances or expenditures of the organization.

4.13 In the event of a death, resignation or removal of any member of the Board of Directors, the President may appoint a successor to fill the vacancy until the next Annual Business Meeting, except as otherwise provided in these Bylaws.

## CHAPTER 5 - EXECUTIVE COMMITTEE

5.01 The Executive Committee shall have authority to act in the interim between regular Board of Directors meetings, unless a special session is called, on all business affairs that are not delegated elsewhere by the Constitution and Bylaws.

5.02 The Executive Committee may take any action, not in conflict with former actions of the membership, as may be necessary to meet unforeseen situations, exercising the full power of the organization, provided it may not act to bind this organization in any way beyond the next regular meeting of the Board of Directors.

## CHAPTER 6 - PRESIDENT

6.01 The term of the President shall last for approximately two years, starting with the election and installation at the Annual Meeting and continuing until the Annual Meeting closest to twenty-four months from that date.

6.02 The President shall counsel with all members of the Executive Committee, Board of Directors, Task Forces/Committee members, and the general membership toward the best interest of the public and of this organization. The President shall attempt to further the aims and objectives of the organization to the fullest extent, and shall perform such other services as custom, necessity and parliamentary procedure require.

6.03 The President in counsel with the Executive Committee shall appoint all Committees/Task Forces, except as otherwise provided. In addition to being a member and the presiding officer of the Executive Committee, the President shall be an *ex-officio* member of all Task Forces/Committees except the Judicial Committee.

6.04 The President, or the President's designee, shall preside and officiate at all major functions and may represent the organization at Local, Regional, District and National meetings.

6.05 The President shall be the organization's representative to the media when issues of importance arise. In carrying out this function, the President may designate other individuals to speak with media outlets. The President is responsible for ensuring that designated individuals appropriately present the official position of the organization.

6.06 The President shall work with the Executive Director and the Executive Vice President to prepare an annual report.

## CHAPTER 7 - PRESIDENT-ELECT

7.01 The President-Elect shall become familiar with the personnel and work of the various Task Forces/Committees and of the organization in general. The President-Elect shall be ready to counsel with the President on matters affecting the future of this organization and otherwise prepare for assuming the leadership of the organization at the proper time.

7.02 The President-Elect shall serve as the Chair of the Council on Governance and shall, in conjunction with the President, appoint the chairs and members of the various committees within the Council. The President-Elect shall also provide oversight to ensure that the various committees within the Council on Governance meet as needed and ensure that reports of their deliberations are provided to the President and the Board of Directors.

7.03 The President-Elect, shall present the recommendations from the Committee on the Constitution and Bylaws concerning the review of the regional geography, starting in 2007 and at least every 5 years thereafter, for membership approval prior to the next Annual Business Meeting.

7.04 The President-Elect shall assist the President in the performance of the duties of office. The President-Elect shall preside in the absence of the President at any meeting of the organization or the Board of Directors and shall represent the President at any meeting when requested.

## CHAPTER 8 - SECRETARY

8.01 The Secretary shall assist the President and President-Elect in the performance of their duties and shall represent the President and/or President-Elect when requested at any meeting of the organization, Committees/Task Forces or at any other function.

8.02 The Secretary shall serve as the Chair of the Council on Advocacy and shall, in conjunction with the President, appoint the chairs and members of the various committees within the Council on Advocacy. The Secretary shall also provide oversight to ensure that the various committees within the Council on Advocacy meet as needed and shall ensure that reports of their deliberations are provided to the President and the Board of Directors.

8.03 The Secretary shall be responsible for oversight, evaluation, and negotiation of terms of engagement for all volunteer and/or contracted Legislative Liaisons working on behalf of the organization.

8.04 The Secretary shall serve as a primary liaison with the Regional and Alternate Regional Representatives to provide orientation and on-going support as they perform their duties.

8.05 The Secretary shall make a significant effort to attend local and regional meetings to represent the organization by informing members and non-members about the activities of the organization, highlighting the benefits of membership.

8.06 The Secretary shall:

a) supervise and handle the secretarial matters of the Society,

b) act as the Corporate Secretary insofar as the execution of official documents or the institution of official actions are required,

c) maintain a current roster of all members and officers of the Society classified according to category of membership,

d) report with reasonable promptness any changes in this roster to the Executive Office of the American Academy of Pediatrics, Incorporated, and

e) act as historian for the Society and as such will update the organization's historical records as appropriate

## CHAPTER 9 - TREASURER

9.01 The Treasurer shall assist the President, President-Elect, and Secretary in the performance of their duties;

9.02 The Treasurer shall represent the President, President-Elect, and/or the Secretary when requested at any meeting of the organization or committees or at any other function.

9.03 The Treasurer shall serve as Chair of the Council on Member Service and shall, in conjunction with the President, appoint the chairs and members of the various committees within the Council on Member Services.

9.04 The Treasurer shall provide oversight to ensure that the various Task Forces within the Council on Member Services meet as needed and shall ensure that reports of their deliberations are provided to the President and the Board of Directors

9.05 The Treasurer shall serve as a primary liaison with the Regional and Alternate Regional Representatives to provide orientation and on-going support as they perform their duties.

9.06 The Treasurer shall make a significant effort to attend local and regional meetings to represent the organization by informing members and non-members about the activities of the organization, highlighting the benefits of membership.

9.07 The Treasurer shall:

a) be the custodian of all monies, securities, valuable papers, books and records of the Society,

b) make deposits in safe banking institutions or invest the Society's monies, subject to the direction of the Board of Directors,

c) pay all authorized obligations of the Society except as provided elsewhere in the Bylaws,

d) keep a detailed account of all receipts and disbursements, and report annually concerning the financial transactions for the preceding year, and

e) perform such other duties as assigned by the Corporate Charter and the Bylaws.

## CHAPTER 10 - EXECUTIVE VICE-PRESIDENT

10.01 An Executive Vice-President may be employed by the organization for the performance of specific duties as outlined by the Board of Directors. The Executive Vice President shall have no vote and shall continue in this position at the pleasure of the Board of Directors and shall be expected to take a certain degree of leadership in the implementation of policy, as befits their background and experience.

10.02 The duties of the Executive Vice-President shall be as follows:

a) The Executive Vice-President shall act as a liaison in all projects that overlap from one administration to the next.

b) To serve as a resource, providing data and expert opinion as required. The Executive Vice-President shall prepare reports, draft contracts and similar binding documents for the final approval of the Board of Directors.

c) To attend all meetings of the Board of Directors designated Committee /Task Force meetings.

d) To work with the Executive Director and oversee record keeping, data retrieval, membership records, financial records, supervision of recurring organization events, and minutes of all major Committee/Task Force meetings.

e) To work with the Executive Director to maintain Executive Offices.

f) To be available to the Executive Director and Committee/Task Force Chairs to assist with Committee/Task Force activities.

g) To Chair the organization's Legislative Committee and serve as a Legislative Liaison to the Florida Legislature, monitoring all child-related actions. The Executive Vice-President shall be prepared to propose remedial legislation for the benefit of the children of Florida, either at the direction of, or with the approval of, the Board of Directors.

h) To maintain contact with child advocacy organizations.

i) To act as liaison with the American Academy of Pediatrics, the Florida Medical Association, the American Medical Association, and other important medically related organizations.

10.03 Qualifications and terms of employment shall be decided by the President and the Board of Directors, or a Task Force designated for that purpose.

## CHAPTER 11 - IMMEDIATE PAST PRESIDENT

11.01 An individual shall assume the office of Immediate Past President upon completing the term of office as President of the organization and coincident with the new President taking office.

11.02 The Immediate Past President shall: Serve as a mentor for incoming officers and/or members of the Board of Directors. Be responsible for recruiting and encouraging new leaders and helping them develop their skills.

11.03 Serve as Chair of the Council of Past Presidents and shall provide oversight to ensure that the various committees within the Council of Past Presidents meet as needed and that reports of their deliberations are provided to the President and the Board of Directors.

## CHAPTER 12 - REGIONAL AND ALTERNATE REGIONAL REPRESENTATIVES

12.01 The Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics shall be composed of geographic Regions. They shall be numerically designated and reviewed to ensure that they appropriately meet the needs of the membership, reflect changing patterns in the distribution of the membership and, where possible, reflect existing pediatric organizations and networks within the state.

12.02 A map showing the counties comprising each region is added as Appendix I to these Bylaws shall be updated as new regional geographic boundaries are approved by the membership.

12.03 Each Representative and Alternate Regional Representative shall have been a voting member of this organization for at least one-year prior to election and shall practice in the elective Region.

12.04 Each Region shall be represented by one Regional Representative and one Alternate Regional Representative with the exception of Region VII and Region VIII who shall be represented by one Regional Representative and two Alternate Regional Representatives. Region membership shall elect an Alternate Regional Representative to serve for a two-year period. This person shall then automatically succeed to the position of Regional Representative without election for the next term and a new Alternate shall be elected.

12.05 Regional and Alternate Regional Representatives shall be responsible for providing two-way communication between the Region and the leadership of the organization utilizing the Executive Committee and the Board of Directors. They shall also be responsible for providing reports to the Board of Directors on regional activities and needs.

12.06 Regional and Alternate Regional Representatives shall be available for appointment to Committees/Task Forces of the organization and may be requested by the President to be the organization's local representative to the media when issues of importance arise. In such instances, the Regional and/or Alternate Regional Representative designated by the President shall take particular care to ensure that the official position of the organization is appropriately represented.

12.07 Regional and Alternate Regional Representatives shall promote membership in the organization and propose recruitment and retention campaigns

12.08 Regional and Alternate Regional Representatives shall serve as ambassadors to non-members and convey information regarding the initiatives, goals and missions of the organization.

12.09 Regional and Alternate Regional Representatives shall Be available to respond to issues regarding health and welfare of infants, children, adolescents and young adults in Florida; and coordinate national and local resources when possible

## CHAPTER 13 - EXECUTIVE DIRECTOR

13.01 An Executive Director may be hired directly or via Management Company engaged by the Board of Directors. The Executive Director shall have no vote and shall serve at the pleasure of the President. The Executive Director shall administer the affairs of the organization based on previous policy and/or other instructions from the Board of Directors.

13.01.1 The Executive Director will provide administrative support to the Executive Committee, governing members and Committees/Task Forces in the development and coordination of specific projects. The Executive Director shall act as a liaison in all projects that overlap from one administration to the next and shall maintain Executive Offices.

13.01.2 The Executive Director shall prepare reports, contracts, agreements and similar binding documents for the final approval of the Board of Directors.

13.01.3 The Executive Director will attend all meetings of the Board of Directors, and designated Committee/Task Force meetings.

13.01.4 The Executive Director shall work with the Executive Vice President and oversee record keeping, data retrieval, membership records, financial records, recurring organization events, and minutes of all major Committee/Task Force meetings.

13.01.5 The Executive Director shall be available to assist all Board of Director Officers and Committee/Task Force chairs with Committees/Task Forces activities.

13.01.6 The Executive Director shall arrange meetings of the organization.

## CHAPTER 14 - ELECTIONS

14.01 The Executive Committee and the Board of Directors shall be elected prior to the Annual Meeting as provided for in these Bylaws. The results shall be announced at the Annual Business Meeting and electronically via email and the web site.

14.02 The Executive Vice-President and the Executive Director shall be responsible for holding and certifying elections in accordance with the Bylaws.

14.03 The current President shall advance to the position of Immediate Past President without the need for election and each Alternate Regional Representative automatically succeeds to the position of Regional Representative in their Region without election.

14.04 Prior to the Annual Meeting, the Executive Vice-President and the Executive Director shall issue a Call for Nominations for any vacancies on the Executive Committee and/or the Board. Elections processes may be conducted via email.

14.05 Should only one nomination for an Alternate Regional Representative position be made from the Region, such nomination shall be equivalent to election.

14.06 Elections for Executive Committee members and Alternate Regional Representatives shall be by secret ballot. Members of the Executive Committee shall be chosen by the entirety of the membership. Members within the geographic Region of each candidate shall choose Alternate Regional Representatives.

14.07 A majority of the votes cast shall be necessary to elect.

14.08 If, on any ballot, no nominee receives a majority, the name receiving the smallest number of votes shall be dropped and the balloting shall continue until a majority is obtained.

14.09 The term of the President, President-Elect, Secretary, Treasurer and Immediate Past President shall last for approximately two years, starting with the election and installation at the Annual Meeting and continuing until the Annual Meeting closest to twenty-four months from that date.

14.10 All officers, representatives and other members elected or appointed to office shall serve until a successor has been duly elected or appointed and has assumed the duties of such office except as otherwise provided in these Bylaws.

## CHAPTER 15 - COMMITTEES

15. 01 The standing Committees of this organization shall be as follows:

1) Committee on the Constitution and Bylaws
2) Committee on Finance
3) Legislative/Advocacy Committee
4) Resident's Section Committee
5) Committee on Continuing Medical Education

6) Committee on Practice Support and Pediatric Council and Pediatric Council & Pediatric Council

7) Council of Past Presidents

8) Nominating Committee

9) Committee on Ethics

10) Judicial Committee

15.02 The President and Executive Committee shall appoint Committee and Task Force Chairpersons and members, except as otherwise provided herein, as soon as possible after assuming the duties of office. The President may also appoint a Chair for any Ad Hoc Committee created for that President's term of office. Nominations for Committee/Task Force membership shall be presented to the Board of Directors for approval at its first meeting following the installation of the new President.

15.03 It should be the aim and purpose of Committee/Task Force work and Committee/Task Force appointments to equitably divide and increase the responsibility of the work of the organization among the individual members, thereby stimulating their personal efforts toward betterment of all conditions affecting physicians, children, individuals and this organization.

15.04 No functions outside of those authorized by the Constitution and the Bylaws may be undertaken by any Committee/Task Force without the approval of the Board of Directors.

15.05 Expenditures by Committee/Task Force may be anticipated and included in the annual budget for presentation to, and approval by, the Board of Directors. Statements for the approved expenditures shall be certified by the Chairs of the Council(s) and forwarded to the Committee on Finance for review and then to the Executive Committee for final approval and inclusion in the budget. It shall then be forwarded to the Executive Director for payment.

15.06.1.1 Committee on the Constitution and Bylaws:

The Committee on the Constitution and Bylaws shall be a Standing Committee, meeting at least twice yearly, with members appointed by the President in counsel with the Executive Committee.

15.06.1.2 The Committee shall perform a periodic review of the organization's Constitution and Bylaws as directed by the President, at least

biennially, with a report to the Board of Directors and the membership at-large.

15.06.1.3 The Committee shall receive, on behalf of the organization, suggestions regarding amendments to the Constitution and Bylaws from active membership, shall analyze and inform the Board of Directors of potential impacts, and shall prepare and disseminate such amendments for discussion and approval.

15.06.1.4 The Committee shall perform a review of the Organizational Structure in conjunction with the biennial review of the Constitution and Bylaws, or as directed by the President.

15.06.1.5 The Committee shall perform a review of the regional geography for presentation to and approval by the membership at the Annual Business Meeting, starting in 2007 and at least every 5 years thereafter.

15.06.2.1 Committee on Finance:

The Committee on Finance shall be a Standing Committee, meeting quarterly, with membership appointed by the President, in counsel with the Executive Committee.

15.06.2.2 The Committee shall provide oversight of the financial affairs of the organization. This includes working in conjunction with the Executive Director to formulate the Annual Budget and present it to the Executive Committee and then the Board of Directors for discussion and approval.

15.06.2.3 The Committee shall receive requests for all Council/Committee expenditures. These requests shall be evaluated and a report on the feasibility and impact of all requests and shall be provided to the Board of Directors at least quarterly.

15.06.2.4 The Committee shall prepare a report on the financial condition of the organization for presentation to the membership at the Annual Business Meeting.

15.07.1.1 The Legislative/Advocacy Committee:

The Legislative/Advocacy Committee shall be a Standing Committee, chaired by the Executive Vice-President in consultation with the President. Its members shall be appointed by the President, in counsel with the Executive Committee.

15.07.1.2 The Committee shall be the primary vehicle for the organization to promote advocacy for children at both the state and federal levels and shall respond to and generate legislative initiatives, consistent with the over-all organizational agenda.

15.07.1.3 The Legislative/Advocacy Committee shall develop a proposed legislative agenda for the organization each year and present it to the Board of Directors for approval no later than September 30th of each year. The Committee shall be responsible for and implementing a plan of action on the legislative agenda and other issues and reporting to the Board of Directors.

15.07.1.4 The Legislative/Advocacy Committee shall meet face-to-face or by teleconference at least weekly during the legislative session and as often as necessary throughout the year to address legislative issues.

15.07.1.5 The Legislative/Advocacy Committee shall work to ensure dissemination of information on legislative affairs to the Board of Directors and the General Membership on a timely basis. The Committee shall create and maintain a system for rapidly activating the membership on issues for importance.

15.07.1.6 The Legislative/Advocacy Committee shall interact on a regular basis with American Academy of Pediatrics state and federal advocacy efforts.

15.07.1.7 The Legislative/Advocacy Committee shall identify key legislative and media contacts in each of the regions to serve as a resource to the organization.

15.07.1.8 The Legislative/Advocacy Committee shall work closely with the Residents' Section and the state's Pediatric Residency Programs to foster the development of advocacy skills and an appreciation of the importance of advocacy among Residents.

15.07.3.9 The Residents' Section:

The Residents' Section shall be chaired by the Resident Section member of the Board of Directors and shall include the Immediate Past President, the Child Advocate and others as appointed. All members shall serve at the pleasure of the Executive Committee.

15.07.3.2 The Committee shall work closely with the Legislative/Advocacy Committee on issues of importance to the organization,

with particular attention to those issues identified by the Residents' Section, as of interest to the Residents in Florida's training programs.

15.07.3.3 The Residents' Section shall identify a key contact at each of the state's Pediatric Training Programs and shall hold at least bi-monthly conference calls to discuss Committee activity, and report to the Board of Directors.

15.08.1.1 Committee on Continuing Medical Education:

The Committee shall explore forums, content and timing to promote the common goals of quality and pediatric educational content; establish the Continuing Education calendar of the organization, including, but not limited to, the Annual Meeting; establish liaisons with existing providers of Continuing Medical Education; and. develop a strategic plan for the educational calendar of the organization.

15.08.2.1 Committee on Practice Support and Pediatric Council

The Committee on Practice Support and Pediatric Council shall be a Standing Committee, chaired by a member of the Council of Past Presidents who is to be appointed by the President, in counsel with the Council Chair. The Committee members shall be appointed by the President, in counsel with the Executive Committee, and shall have at least two members appointed from the general membership. All members shall serve at the pleasure of the President.

15.08.2.2 The Committee shall:

Identify areas of concern from among the membership; research and publicize potential solutions; disseminate this information to the membership; Report to the Board of Directors.

15.09.1.1 Nominating Committee:

The Nominating Committee shall be a Standing Committee, chaired by the Immediate Past President. The Committee members shall be appointed by the President, in counsel with the Council Chair, with representation from the Board of Directors and the general membership. All members shall serve at the pleasure of the Council Chair.

15.09.1.2 The Committee shall be charged with producing, at the appropriate time, up to two candidates for each of the elective offices to be voted upon by the general membership.

15.10.2.1 Committee on Ethics:

The Committee on Ethics shall be a Standing Committee, chaired by the President, with two members appointed from the Council of Past Presidents, two Regional or Alternate Regional Representatives and the Executive Director, who shall serve in an *ex-officio* capacity. All members shall serve at the pleasure of the Council Chair.

15.10.2.2 The Committee shall meet at the request of any member of the Board of Directors.

15.10.2.3 The Committee shall provide counsel to the President in matters of organizational ethics and shall refer all matters involving personal ethics to the Judicial Committee.

15.10.3.1 Judicial Committee:

The Judicial Committee shall be a Standing Committee, with membership appointed by the President, in counsel with the Council Chair, from among the Executive Committee, the Council of Past Presidents and the Regional and Alternate Regional Representatives. This Committee shall meet as needed. All members shall serve at the pleasure of the Council Chair, unless the chair is involved. Those matters shall be handled by existing Committee Members.

15.10.3.2 The Committee shall consider matters related to the Membership-at-Large, the Executive Committee, and the Board of Directors, regarding professional conduct, personal ethics, moral turpitude, felony convictions and other behaviors that may adversely affect the well-being, reputation or standing of the organization, or may be contrary to the Constitution and Bylaws, and may require disciplinary action.

15.11.3.3 The Committee shall develop policies and procedures regarding the method of conducting an investigation and resolving matters brought before the Committee.

15.11.3.4 The Committee shall serve as the investigative body regarding these matters and shall provide a report to the Board of Directors suggesting a course of action.

15.11.3.5 The Committee shall have the authority to request legal counsel regarding those matters that may come to its attention.

15.11.3.6 The Committee shall use the Principles of Medical Ethics of the American Medical Association as its guide as well as the Statements on general ethics, Antitrust and Conflict of Interest adopted by the organization.

## CHAPTER 16 - ETHICS

16.01 The Principles of Medical Ethics of the American Medical Association (APPENDIX II) shall govern the conduct of members in their relation to each other and the public. Any member violating these principles shall be deemed to have committed a breach of medical ethics and may be liable to such disciplinary action as the Judicial Committee or Committee on Ethics may decide.

## CHAPTER 17 - AMENDMENT OF BYLAWS

17.01 A copy of any proposed changes to the Bylaws shall be sent to the Board of Directors for review. Any proposed changes accepted by the Board shall be sent to the members not less than thirty days prior to the Annual Business Meeting.

17.02 The general membership may amend, alter or rescind proposed changes that have been approved and circulated by the Board of Directors at the Annual Business Meeting, when a quorum is present, or by mail or electronic voting if the changes occur after the Annual Business Meeting has occurred.

## CHAPTER 18 - REFERENDUM

18.01 The membership at a regular session, or the Board of Directors by a two-thirds vote of the Directors present, may order a general referendum on any question pending before the meeting or the Board of Directors.

18.02 The question shall be submitted to all members eligible to vote within the organization, who may vote by electronic or written means. A majority of all of those votes received shall determine the question.

18.03 When submitting the question, the President may fix a time limit of no less than thirty days within which the Executive Office must receive a member's vote.

## CHAPTER 19 - IMPEACHMENT

19.01 All charges for impeachment shall be directed to the Executive Committee in writing and shall be signed by at least five members who thereby agree to substantiate their statements with proof. The Executive Committee, after such

charges are received, may suspend the subject individual from office until the matter is resolved.

19.02 If the Judicial Committee or the Committee on Ethics, after a diligent and careful investigation, finds a just and sufficient cause for removal of a particular officer, it shall, upon fifteen days notice to the subject individual, present its findings and recommendations to the Board of Directors at a regular or special session. The subject individual may offer supportive evidence and witnesses.

19.03 Any officer, delegate or other official of this organization may be impeached and removed from office upon a two-thirds vote of the Board of Directors at a regular or a special session.

19.04 A successor for the unexpired term of an impeached official shall be designated in accordance with the Constitution and Bylaws.

## CHAPTER 20 - FUNDS AND EXPENSES

20.01 Funds of this organization shall be raised by an annual per capita assessment.

20.02 Funds may also be derived from voluntary contributions, bequests, patents, copyrights, income from this organization's publications, and from any other source or manner approved by the Board of Directors in accordance with the Constitution and Bylaws and in compliance with the laws of the State of Florida.

20.03 Funds may be appropriated, and approved by the Board of Directors to defray the expenses of this organization and for such other purposes as shall promote the goals and objectives of the organization in accordance with the Constitution and Bylaws and in compliance with the laws of the State of Florida.

## CHAPTER 21 - RULES OF ORDER

21.01 All deliberations of the membership or any group thereof shall be governed by parliamentary procedure contained in the latest edition of *Robert's Rules of Order, Newly Revised* when not in conflict with the Constitution and Bylaws.

## CHAPTER 22 - LOGO USAGE AND REPRESENTATION

22.01 The Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics logo is a registered trademark, the exclusive property of The Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics and may only be used for official business by the Executive Offices, members of the

Board of Directors, and Councils/Committees or affiliate associations as authorized by the Board of Directors.

22.02 Use of the logo or the name of the organization in endorsements, advertising or promotional materials is restricted to the organization and those with written approval of the Board of Directors. The logo may not be used in endorsements, advertisements or materials created for the purpose of solicitation when prepared on behalf of an individual member or on behalf of an informal association of members.

22.03 Any other use of the logo is prohibited unless written permission is obtained prior to use from the Board of Directors. Such unauthorized use shall subject the user to disciplinary action possibly including termination of membership and/or civil suit for violation of copyright material.

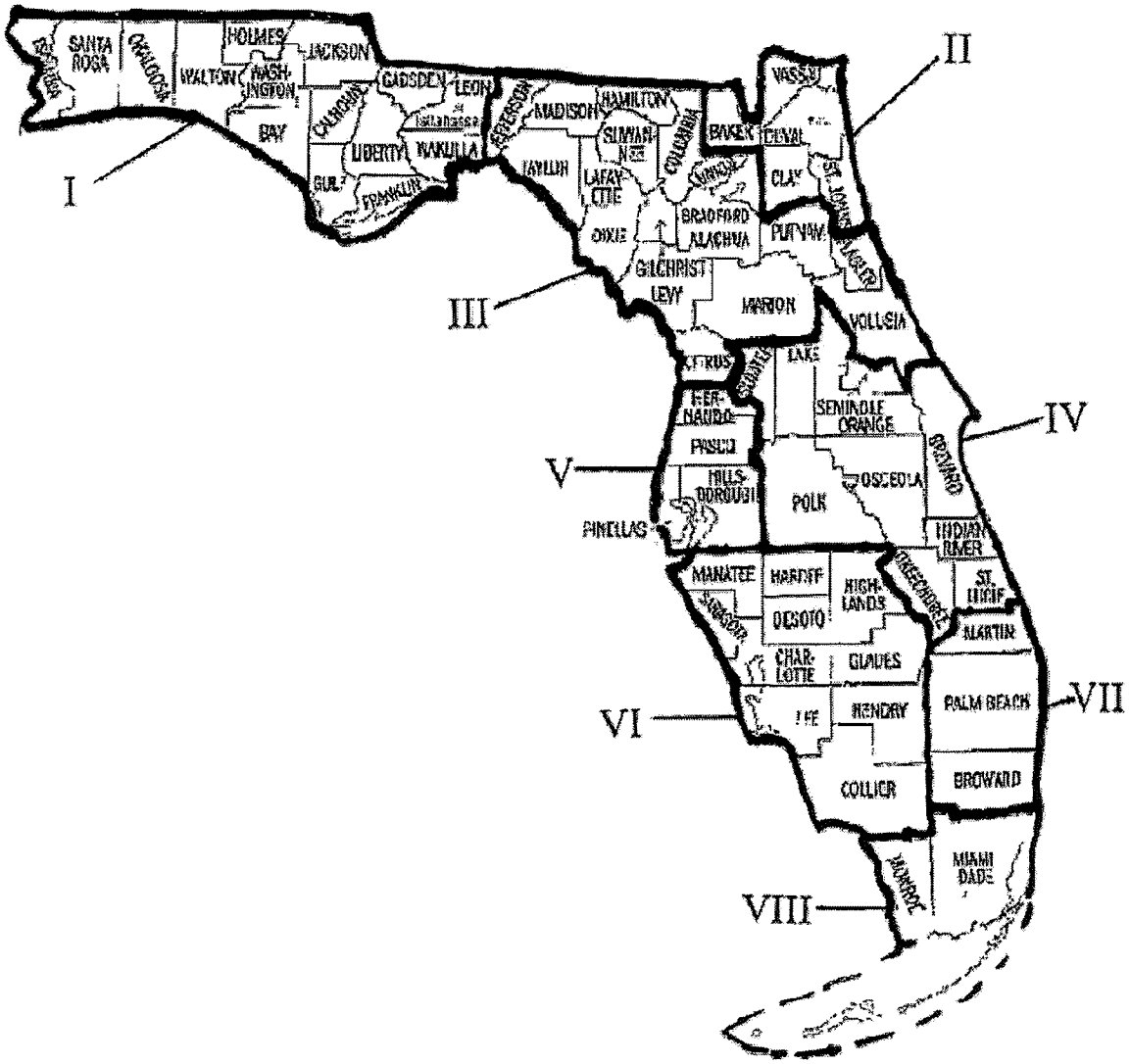
22.04 The logo may only be used on stationery (envelopes and letterhead), business cards, newsletters, brochures, and electronic media produced by the Executive Offices or entities designated by the Board of Directors.

## CHAPTER 23 - AFFILIATION

23.01 This organization is a component society of the American Academy of Pediatrics, and is possessed only of those rights and powers conferred on it by the opinion of the American Academy of Pediatrics

23.02 No rules, regulations or policies adopted by this organization shall be in conflict with those of the American Academy of Pediatrics, or the laws of the State of Florida.

## APPENDIX I: REGION MAP FOR FPS




Revised 5/8/10

**Counties by Region**

**Region I**: Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Washington, Walton

**Region II**: Baker, Clay, Duval, Nassau, St. Johns

**Region III**: Alachua, Bradford, Citrus, Columbia, Dixie, Flagler, Gilchrist, Hamilton, Jefferson, Lafayette, Levy, Madison, Marion, Putnam, Suwannee, Taylor, Union, Volusia

**Region IV**: Brevard, Indian River, Lake, Okeechobee, Orange, Osceola, Polk, Seminole, St. Lucie, Sumter

**Region V**: Hernando, Hillsborough, Pasco, Pinellas

**Region VI**: Charlotte, Collier, De Soto, Glades, Hardee, Hendry, Highlands, Lee, Manatee, Sarasota

**Region VII**: Broward, Palm Beach, Martin

**Region VIII**: Miami-Dade, Monroe

Revised 5/8/10

## APPENDIX II: AMERICAN MEDICAL ASSOCIATION PRINCIPLES OF MEDICAL ETHICS

**Preamble**:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interest of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

***Adopted by the AMA's House of Delegates on June 17, 2001.***

Revised 5/8/10

## APPENDIX III: HISTORICAL INFORMATION

### DATES

| | |
|---|---|
| Inaugural Session of the Florida Pediatric Society | 1936 |
| 1st Charter Meeting of the Florida Pediatric Society | 1940 |
| Florida Chapter of the American Academy of Pediatrics created | 1952 |
| FPS Incorporated | 1962 |
| FPS and FCAAP Combine Efforts | 1967 |
| FCAAP wins Large Chapter Award | 1975 |
| Board of Directors Retreats started | 1989 |
| FPS and FCAAP amalgamated | 1994 |
| FCAAP wins Large Chapter Award | 1993 |

### NARRATIVE SUMMARY

The inaugural session of the Florida Pediatric Society (FPS) was held on April 27, 1936 aboard the Steamship Florida. The first meeting under the new Charter was held in Tampa on April 28, 1940.

In 1951, Warren Quillian, a Floridian, was installed as President of The American Academy of Pediatrics (AAP). As first Southeasterner to hold this office, he encouraged the formation of a state Chapter to carry out committee and other activities for the benefit of children. The Florida Chapter was formed on April 27, 1952.

After two years of study and deliberation, the FPS and the Florida Chapter of the American Academy of Pediatrics (FCAAP) merged. With that merger, every Florida member of the AAP became member of FCAAP. A new Constitution and Bylaws for the combined group were ratified on September 22, 1967.

Over the past 70 years, the FPS has served children and pediatricians and won the AAP Large Chapter Award twice, once in 1975 and again in 1993.

A more complete narrative is available upon request to the Executive Offices.

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**FPS Past Presidents**

889 1936-37 Luther W. Holloway, MD
890 1937-38 Shalliam W. McKibben,
891 MD
892 1938-39 Douglas O. Martin, MD
893 1939-42 Warren W. Quillian, MD
894 1942-46 Ludo Von Meysenbug,
895 MD
896 1946-47 Councill C. Rudolph, MD
897 1947-48 James R. Boulware, MD
898 1948-49 Edgar W. Stephens, MD
899 1949-50 Hugh A. Carithers, MD
900 1950-51 Edgar Hitchcock, MD
901 1951-52 E. V. Anderson, MD
902 1952-53 Charlotte Maguire, MD
903 1953-54 C. Jennings Derrick, MD
904 1954-55 Lewis T. Corum, MD
905 1955-56 Wesley S. Nock, MD
906 1956-57 Joel V. McCall, MD
907 1957-58 Henry G. Morton, MD
908 1958-59 Burns A. Dobbins, MD
909 1959-60 Harry M. Edwards, MD
910 1960-61 Joseph K. David, MD
911 1961-62 Fred I. Dorman, MD
912 1962-63 John H. Cordes, MD
913 1963-64 George W. Griffin, MD
914 1964-65 Robert J. Grayson, MD
1965-66 Oliver F. Deen, MD
1966-67 James M. Weaver, MD
1967-68 Richard Skinner, MD
1968-69 Ray O. Edwards, MD
1969-70 Thomas M. Brill, MD
1970-71 John C. Moore, MD
1971-72 James M. Stem, MD
1972-73 Bernard F. O'Hara, MD
1973-74 David R. Gair, MD
1974-75 James M. San, MD
1975-76 W. Reed Bell, MD
1976-77 Andrews W. Townes, MD
1977-78 Michael Steiner, MD
1978-79 Thomas Greiwe, MD
1979-80 Myrna B. Ginter, MD
1980-82 George A. Richard, MD
1982-84 Donald I. Macdonald, MD
1984-87 Marcus M. Moore, MD
1987-89 Gary M. Bong, MD
1989-91 George A. Dell, MD
1991-93 Robert F. Colyer, MD
1993-95 Kenneth H. Morse, MD

Revised 5/8/10

**The FCAAP Past Presidents**

| | | | | |
|---|---|---|---|---|
| 1935-40 | Warren W. Quillian, MD | 1970-75 | Robert J. Grayson, MD |
| 1941-42 | Gilbert S. Osincup, MD | 1976-78 | F. Edwards Rushton, MD |
| 1942-48 | George L. Cook, MD | 1979-81 | W. Reed Bell, MD |
| 1949-51 | James R. Boulware, MD | 1982-84 | Robert H. Threlkel, MD |
| 1952-57 | Hugh A. Carithers, MD | 1985-88 | Arnold L. Tanis, MD |
| 1958-63 | Wesley S. Nock, MD | 1989-92 | John H. Whitcomb, MD |
| 1964-69 | Henry G. Morton, MD | 1992-95 | David A. Cimino, MD |

**The FPS/FCAAP Past Presidents**

| | |
|---|---|
| 1995-97 | John S. Curran, MD |
| 1997-99 | Edward T. Williams, MD |
| 1999-01 | Edward N. Zissman, MD |
| 2001-03 | Richard Bucciarelli, MD |
| 2003-05 | Deborah Mulligan, MD |
| 2005-07 | David Marcus, MD |
| 2007-08 | Jorge Del Toro-Silvestry, MD |
| 2008 -10 | Jerry H. Isaac, MD |
| 2010 – 12 | Lisa Cosgrove, MD |

Revised 5/8/10

# COSGROVE EXHIBIT 2

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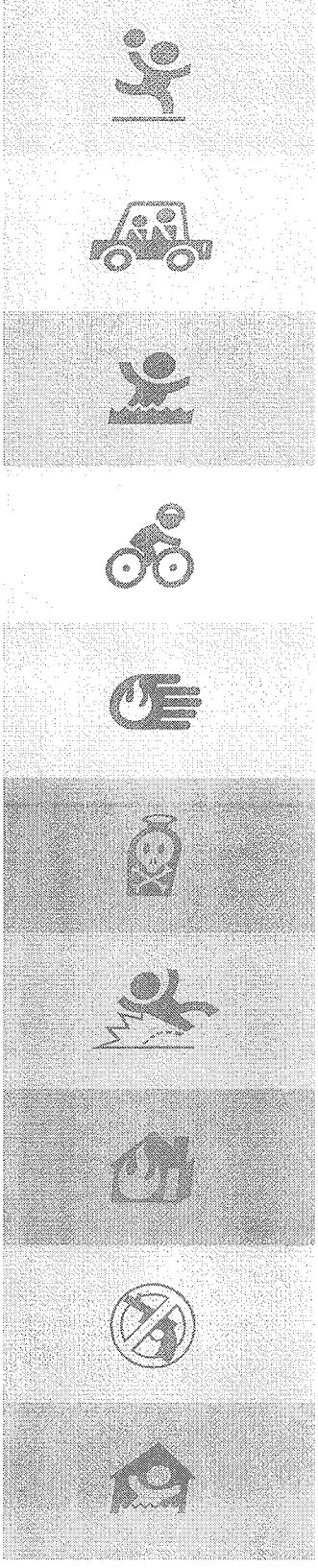

# A guide to SAFETY COUNSELING in Office Practice

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# IMPLEMENTING SAFETY COUNSELING IN OFFICE PRACTICE

TIPP was developed and is maintained by the American Academy of Pediatrics Committee on Injury, Violence, and Poison Prevention.

The development of the original TIPP materials was partially supported by the Division of Maternal and Child Health, US Department of Health and Human Services.

For additional copies, contact
American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1098

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



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# INTRODUCTION

In April 1983 the American Academy of Pediatrics (AAP) initiated The Injury Prevention Program (TIPP) for children from birth to 4 years of age. In October 1988 TIPP was expanded to include children from 5 to 12 years of age. In 1994 it was revised, and it was updated again in 2001 to reflect the current pattern of childhood injuries.

TIPP is an educational program for parents of children newborn through 12 years of age to help prevent common injuries from

- Motor vehicles
- Firearms
- Bicycle crashes
- Drowning
- Poisoning
- Choking
- Burns
- Falls
- Pedestrian hazards

TIPP is designed to provide a systematic method for pediatricians to counsel parents and children about adopting behaviors to prevent injuries—behaviors that are effective and capable of being accomplished by most families.

TIPP comprises 3 major elements

- A policy statement on injury prevention approved by the AAP
- Childhood Safety Counseling Schedules for early and middle childhood
- A package of materials consisting of Safety Surveys and age-specific, color-coded Safety Sheets for use in providing anticipatory guidance to parents and children

The TIPP schedules recommend the types of injuries that should be discussed at each health supervision visit and suggest materials to assist you in counseling. The Safety Sheets contain targeted, age-specific messages to be given to all parents. The Safety Surveys identify areas of individual risk that may need additional specific counseling.

TIPP can be integrated into your practice by

1. Having a parent answer a Safety Survey in your reception room (The child should complete the survey at 10 years of age.)
2. Having the completed survey placed in the child's chart for your review
3. Noting "at-risk" answers on surveys that have been completed, which is easy to do because only these answers appear on the second page (carbonless copy) of the survey
4. Counseling the parent or child on specific injury prevention behaviors using the Safety Sheets and the counseling guidelines prompted by the "at-risk" answers obtained from surveys
5. Reinforcing your counseling by giving the parent or child an age-appropriate Safety Sheet emphasizing the targeted safety messages of the counseling schedule
6. Documenting this counseling in the medical record

Counseling parents and children about the prevention of common childhood injuries is an important contribution toward preventing the major cause of childhood morbidity and mortality. Primary care pediatricians can have a significant impact on injury prevention through counseling. A comprehensive review of the literature conducted jointly by the Section and Committee on Injury and Poison Prevention (*Pediatrics*, October 1993) showed that of 20 studies of injury prevention counseling in primary care settings, 18 demonstrated positive results including improved knowledge, improved behavior, and even a decrease in the number of injuries involving motor vehicles and nonmotor vehicles. Given the proper advice and encouragement from their physician, parents can be motivated to protect their children from injuries.

The pediatrician should remain an active advocate to change social attitudes about childhood injuries at the local, state, and national levels. The effectiveness of the pediatrician in this capacity has best been demonstrated by the now universal infant car safety seat legislation, as well as the expectation of car safety seat use as a social norm. The participation and support of pediatricians nationwide were important factors in this accomplishment.

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# OVERVIEW OF PROGRAM

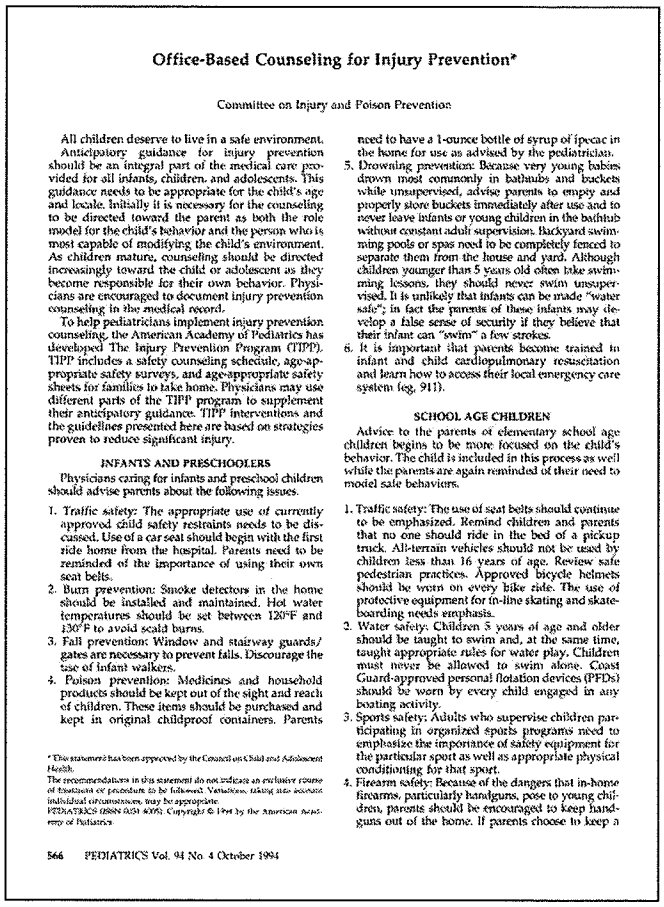
## Injury Prevention as a Standard of Care

The 1983 policy statement, "Injury Prevention," by the American Academy of Pediatrics (AAP) was an important addition to the standards of health care for infants and preschool children. It was updated in 1988 to include safety counseling for school-aged children and was revised again in 1994 (Figure 1—see published AAP policy statement included in folder materials).

To help the practitioner implement this standard, the AAP has developed a schedule of recommended counseling for each preventive health visit and a package of materials for office use. The materials include Safety Sheets to be given to all parents and Safety Surveys that are designed to help identify the counseling needs of each family. All the materials have been tested in a variety of practices and were found to be easy to use and well accepted by parents and pediatricians. The injuries selected for counseling were chosen on the basis of sound epidemiologic data reflecting the most common causes of death and disability in childhood.

To assist you in counseling parents, the "Early Childhood Safety Counseling Schedule" and "Middle Childhood Safety Counseling Schedule," which follow (pages 6 and 7, respectively), have been developed. The schedules are designed to introduce and reinforce important safety concepts in an organized manner. The entire program is designed to emphasize those injuries that are developmentally most important for parents to anticipate and prevent injuries.

We realize that each pediatric practice is different, but our hope is that the counseling schedule will be of use as an organizational framework. TIPP is designed so that injury prevention counseling can be specific to the needs of your patients and practice.



**Office-Based Counseling for Injury Prevention***

Committee on Injury and Poison Prevention

All children deserve to live in a safe environment. Anticipatory guidance for injury prevention should be an integral part of the medical care provided for all infants, children, and adolescents. This guidance needs to be appropriate for the child's age and locale. Initially it is necessary for the counseling to be directed toward the parent as both the role model for the child's behavior and the person who is most capable of modifying the child's environment. As children mature, counseling should be directed increasingly toward the child or adolescent as they become responsible for their own behavior. Physicians are encouraged to document injury prevention counseling in the medical record.

To help pediatricians implement injury prevention counseling, the American Academy of Pediatrics has developed The Injury Prevention Program (TIPP). TIPP includes a safety counseling schedule, age-appropriate safety surveys, and age-appropriate safety sheets for families to take home. Physicians may use different parts of the TIPP program to supplement their anticipatory guidance. TIPP interventions and the guidelines presented here are based on strategies proven to reduce significant injury.

INFANTS AND PRESCHOOLERS

Physicians caring for infants and preschool children should advise parents about the following issues.

1. Traffic safety: The appropriate use of currently approved child safety restraints needs to be discussed. Use of a car seat should begin with the first ride home from the hospital. Parents need to be reminded of the importance of using their own seat belts.
2. Burn prevention: Smoke detectors in the home should be installed and maintained. Hot water temperatures should be set between 120°F and 130°F to avoid scald burns.
3. Fall prevention: Window and stairway guards/gates are necessary to prevent falls. Discourage the use of infant walkers.
4. Poison prevention: Medicines and household products should be kept out of the sight and reach of children. These items should be purchased and kept in original childproof containers. Parents need to have a 1-ounce bottle of syrup of ipecac in the home for use as advised by the pediatrician.
5. Drowning prevention: Because very young babies drown most commonly in bathtubs and buckets while unsupervised, advise parents to empty and properly store buckets immediately after use and to never leave infants or young children in the bathtub without constant adult supervision. Backyard swimming pools or spas need to be completely fenced to separate them from the house and yard. Although children younger than 5 years old often take swimming lessons, they should never swim unsupervised. It is unlikely that infants can be made "water safe"; in fact the parents of these infants may develop a false sense of security if they believe that their infant can "swim" a few strokes.
6. It is important that parents become trained in infant and child cardiopulmonary resuscitation and learn how to access their local emergency care system (eg, 911).

SCHOOL AGE CHILDREN

Advice to the parents of elementary school age children begins to be more focused on the child's behavior. The child is included in this process as well while the parents are again reminded of their need to model safe behaviors.

1. Traffic safety: The use of seat belts should continue to be emphasized. Remind children and parents that no one should ride in the bed of a pickup truck. All-terrain vehicles should not be used by children less than 16 years of age. Review safe pedestrian practices. Approved bicycle helmets should be worn on every bike ride. The use of protective equipment for in-line skating and skateboarding needs emphasis.
2. Water safety: Children 5 years of age and older should be taught to swim and, at the same time, taught appropriate rules for water play. Children must never be allowed to swim alone. Coast Guard-approved personal flotation devices (PFDs) should be worn by every child engaged in any boating activity.
3. Sports safety: Adults who supervise children participating in organized sports programs need to emphasize the importance of safety equipment for the particular sport as well as appropriate physical conditioning for that sport.
4. Firearm safety: Because of the dangers that in-home firearms, particularly handguns, pose to young children, parents should be encouraged to keep handguns out of the home. If parents choose to keep a

* This statement has been approved by the Council on Child and Adolescent Health.
The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.
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566 PEDIATRICS Vol. 94 No. 4 October 1994

**Figure 1**

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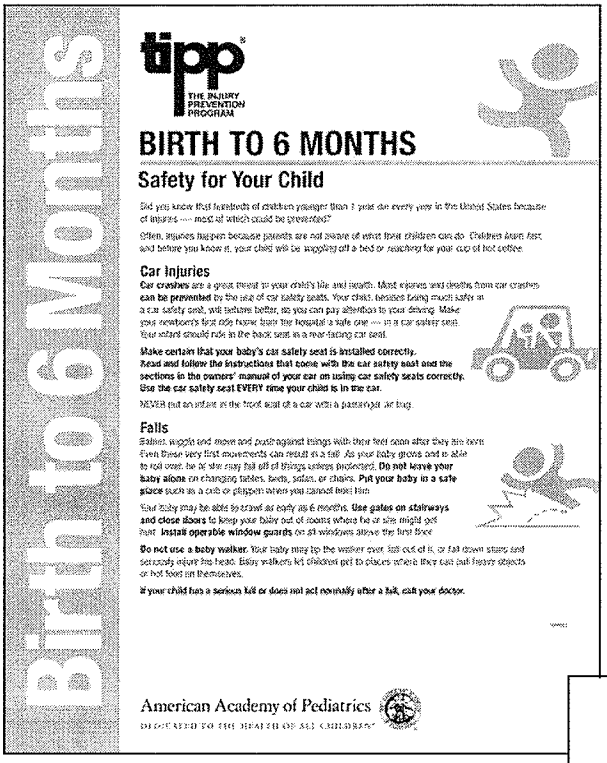
Birth to 6 Months

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BIRTH TO 6 MONTHS

Safety for Your Child

Did you know that hundreds of children younger than 1 year die every year in the United States because of injuries — most of which could be prevented?

Often, injuries happen because parents are not aware of what their children can do. Children learn fast, and before you know it, your child will be wiggling off a bed or reaching for your cup of hot coffee.

Car Injuries

**Car crashes** are a great threat to your child's life and health. Most injuries and deaths from car crashes **can be prevented** by the use of car safety seats. Your child, besides being much safer in a car safety seat, will behave better, so you can pay attention to your driving. Make your newborn's first ride home from the hospital a safe one — in a car safety seat. Your infant should ride in the back seat in a rear-facing car seat.

**Make certain that your baby's car safety seat is installed correctly. Read and follow the instructions that come with the car safety seat and the sections in the owners' manual of your car on using car safety seats correctly. Use the car safety seat EVERY time your child is in the car.**

NEVER put an infant in the front seat of a car with a passenger air bag.

Falls

Babies wiggle and move and push against things with their feet soon after they are born. Even these very first movements can result in a fall. As your baby grows and is able to roll over, he or she may fall off of things unless protected. **Do not leave your baby alone** on changing tables, beds, sofas, or chairs. **Put your baby in a safe place** such as a crib or playpen when you cannot hold him.

Your baby may be able to crawl as early as 6 months. **Use gates on stairways and close doors** to keep your baby out of rooms where he or she might get hurt. **Install operable window guards** on all windows above the first floor.

**Do not use a baby walker.** Your baby may tip the walker over, fall out of it, or fall down stairs and seriously injure his head. Baby walkers let children get to places where they can pull heavy objects or hot food on themselves.

**If your child has a serious fall or does not act normally after a fall, call your doctor.**

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**Figure 2**

**Figure 3**

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THE FIRST YEAR OF LIFE

Framingham Safety Survey

Name _____ Date _____

Please X through one answer for each question.

| | | | |
|---|---|---|---|
| 1. Do you put the crib side up whenever you leave your baby in the crib? | Always | Sometimes | Never |
| 2. Do you keep the baby alone on tables or beds, even for a brief moment? | Frequently | Occasionally | Never |
| 3. Do you leave the baby alone at home? | Frequently | Occasionally | Never |
| 4. Do you keep plastic wrappers, plastic bags, and balloons away from your children? | Always | Sometimes | Never |
| 5. Does your child wear a pacifier or jewelry around his or her neck? | Frequently | Occasionally | Never |
| 6. Does your child play with small objects such as beads or nuts? | Frequently | Occasionally | Never |
| 7. Are any of your baby-sitters younger than 13 years? | Yes | Don't know | No |
| 8. How frequently is the heating system checked where you live? | Never | At least once a year | Every few years |
| 9. Are your operable window guards in place? | All windows | Some windows | None |
| 10. Do you ever place your baby in an infant walker? | Yes | No | |
| 11. Does anyone in your home ever smoke? | Frequently | Occasionally | Never |
| 12. Do you have a plan for escape from your home in the event of a fire? | Yes | No | |
| 13. Do you have working fire extinguishers in your home? | Yes | Don't know | No |
| 14. Do you have working smoke alarms in your house? | Yes | No | |
| 15. Do you ever drink or carry hot liquids when holding your baby? | Frequently | Occasionally | Never |
| 16. Do you ever use woodstoves or kerosene heaters? | Yes | No | |
| 17. Do you leave the baby alone in or near a tub, bath water or toilet, even for a brief moment? | Frequently | Occasionally | Never |
| 18. Do you have a pool or hot tub where you live? | Yes | No | |
| 19. Do you use a car safety seat in the car on every trip at all times? | Yes | No | |
| 20. Does your car have a passenger air bag? | Yes | No | |
| 21. Where do you place your child's car safety seat in the car? | Front | Rear | Front or rear |
| 22. Does your child ride on your bicycle with you? | Frequently | Occasionally | Never |
| 23. Is there a gun in your home or the home where your child plays or is cared for? | Yes | Don't know | No |

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A sample Safety Sheet and Safety Survey are shown in Figures 2 and 3. All the materials are color coded to simplify using the program in your practice. There are 8 separate Safety Sheets: the handouts for children from birth to 6 months, 6 to 12 months, 1 to 2 years, and 2 to 4 years of age contain messages for parents; and the handouts for children 5, 6, 8, and 10 years of age contain messages for parents on 1 side, with games and puzzles for children on the other side. Four Safety Surveys have been designed for parents of infants, toddlers 1 to 4 years of age (parts 1 and 2), and children 5 to 9 years of age. In addition, a special Safety Survey is available for children 10 to 12 years of age to complete at the health maintenance visit.

Samples of all the Safety Sheets and Safety Surveys can be found in the folder pocket at the end of this guide.

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# EARLY CHILDHOOD

## Safety Counseling Schedule

| PREVENTIVE HEALTH VISIT AGE | MINIMAL SAFETY COUNSELING INTRODUCE | REINFORCE | MATERIALS |
|---|---|---|---|
| Prenatal/ Newborn | Infant Car Safety Seat<br>Smoke Alarm<br>Crib Safety | | AAP Car Safety Seats: A Guide for Families<br>Infant Furniture TIPP Slip |
| 2 Days to 4 Weeks | Falls | Infant Car Safety Seat | |
| 2 Months | Burns—Hot Liquids<br>Choking/Suffocation | Infant Car Safety Seat<br>Falls | Blue Safety Sheet (Birth–6 Months)<br>AAP Choking Brochure |
| 4 Months | Water Safety—Bathtubs | Infant Car Safety Seat<br>Falls<br>Burns—Hot Liquids<br>Choking/Suffocation | Blue Safety Survey<br>Blue Safety Sheet (Birth–6 Months) |
| 6 Months | Poisonings<br>Burns—Hot Surface | Falls<br>Burns—Hot Liquids<br>Choking | Beige Safety Sheet (6–12 Months)<br>Poison TIPP Slip<br>Poison Help Line Sticker or Magnet |
| 9 Months | Water/Pool Safety<br>Convertible Car Safety Seat<br>Firearm Hazards | Poisonings<br>Falls<br>Burns | AAP Car Safety Seats: A Guide for Families<br>Beige Safety Sheet (6–12 Months)<br>Firearms Safety TIPP Slip |
| 1 Year | | Water/Pool Safety<br>Falls<br>Burns | Yellow Safety Sheet (1–2 Years)<br>Water/Pool Safety TIPP Slips |
| 15 Months | | Car Safety Seat<br>Poisonings<br>Falls<br>Burns | Yellow Safety Survey<br>Yellow Safety Sheet (1–2 Years) |
| 18 Months | | Car Safety Seat<br>Poisonings<br>Falls<br>Burns<br>Firearm Hazards | Yellow Safety Sheet (1–2 Years) |
| 2 Years | Falls—Play Equipment, Tricycles/Helmets<br>Pedestrian Safety | Car Safety Seat<br>Water/Pool Safety<br>Burns<br>Firearm Hazards | Green Safety Survey<br>Green Safety Sheet (2–4 Years)<br>Playground Safety TIPP Slip |
| 3 Years | | Car Safety Seat<br>Pedestrian Safety<br>Falls<br>Burns<br>Firearm Hazards | Green Safety Sheet (2–4 Years) |
| 4 Years | Booster Seat Use | Pedestrian Safety<br>Falls—Play Equipment<br>Firearm Hazards | AAP Car Safety Seats: A Guide for Families<br>Green Safety Sheet (2–4 Years) |

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# MIDDLE CHILDHOOD

## Safety Counseling Schedule

| PREVENTIVE HEALTH VISIT AGE | MINIMAL SAFETY COUNSELING INTRODUCE | REINFORCE | MATERIALS |
|---|---|---|---|
| 5 Years | Water/Pool Safety<br>Bicycle Safety | Firearm Hazards<br>Pedestrian Safety<br>Booster Seat Use | Pink Safety Sheet<br>(5–6 Years)<br>Water Safety TIPP Slips |
| 6 Years | Fire Safety | Bicycle Safety<br>Booster Seat Use<br>Pedestrian Safety<br>Firearm Hazards | Peach Safety Survey<br>Peach Safety Sheet<br>(6–8 Years)<br>Fire Safety TIPP Slip |
| 8 Years | Sports Safety<br>Seat Belt Use | Bicycle Safety | Purple Safety Sheet<br>(8–10 Years) |
| 10 Years | Firearm Hazards | Sports Safety<br>Seat Belt Use<br>Bicycle Safety | Gold Safety Survey<br>Gold Safety Sheet<br>(10–12 Years) |

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# IDEAS FOR OPTIMAL USE OF TIPP®

1. Ask your front desk staff to give the questionnaire to the parent to complete while in the waiting room and to instruct parents to answer each question by using an "X" to cross out their answer.

2. Ask your staff to attach the appropriate Safety Sheets and the completed Safety Surveys to the child's record before you see the child.

3. TIPP Safety Sheets work best when parents know why they should rethink protective measures for their child at different age levels. While taking the patient's history, ask the parents about their safety behavior. Do they use a car safety seat every time the baby rides in the car? Where is the child placed when the parents are cooking?

4. While the child is being examined, point out his or her developmental capabilities and the risk for specific injuries such as falling off a table, eating foreign objects, poisoning, or choking. Use the Safety Sheets and Safety Surveys as a guide for what injuries to discuss with the parent.

5. Ask the parents what will make it hard for them to establish the safety practices you recommend. Ask them to come up with ways they can make these practices a habit.

6. Stress that injuries pose the greatest threat to their child's life. Talk about protecting their child against possible death and disability by adopting the recommended behaviors.

7. During the initial use of TIPP and until you are familiar with it, it's not necessary to survey your entire practice at once. Start gradually, with 3- to 4-year-olds for example, and as you become more familiar with the questionnaire, you will find it easy to expand your counseling efforts to include more of your patients.

8. Remember to record the counseling given in the medical record. Institute a method of recording the completed parts of the program on your patient's chart. A stamp with a check-off list may be helpful. Keep the physician's copy of the Safety Survey in the patient's chart.

9. Additional reference material is available from the American Academy of Pediatrics (AAP) on a wide variety of injury prevention issues (see page 20). The AAP *First Aid Chart* and the AAP brochure *Choking Prevention and First Aid for Infants and Children* may be of particular help. These materials can be distributed so that they can be used by parents when an at-risk situation occurs. The AAP also has a program for intentional injury prevention counseling—*Connected Kids: Safe, Strong, Secure*™.

10. Periodic reminders to your nursing staff to use these TIPP materials will underscore your aim to incorporate TIPP as a permanent addition to your practice.

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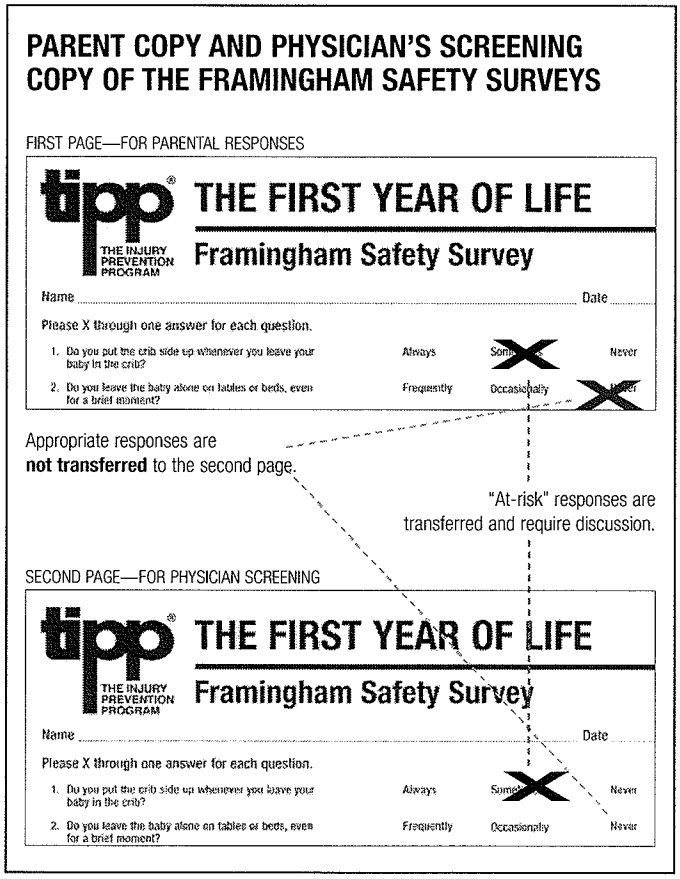
# FRAMINGHAM SAFETY SURVEYS

## PARENT COPY AND PHYSICIAN'S SCREENING COPY OF THE FRAMINGHAM SAFETY SURVEYS




# Instructions for Use

The Framingham Safety Surveys are a series of developmentally oriented questionnaires designed to identify those areas of injury prevention in which the parents and child may be in need of counseling.

The surveys should be administered at certain health supervision visits.

- 2-month visit (blue)
- 15-month visit (yellow)
- 2-year visit (green)
- 6-year visit (peach)
- 10-year visit (gold)

Although these times are suggestions, the surveys can be given at any health supervision visit within the appropriate age ranges.

Each survey is a multiple-choice questionnaire that the parent completes while waiting to see the pediatrician.

- The parent fills in the first page.
- The physician uses the second page to screen the responses.
- All Xs appearing on the white (second) page of the survey indicate possible risk and merit further discussion (see illustration).
- At 10 years of age, the child completes the survey.

The surveys have been designed not to disrupt your office or clinic routine. Studies involving more than 30 pediatricians in a variety of settings have shown the program to be well received by parents and readily adaptable to pediatric practice.

Approximately 3 minutes is required by the parent to fill out the survey in the waiting room. In addition, counseling time by the physician is approximately 3 minutes. Suggested counseling guidelines are available on the pages that follow. Remember that these surveys are designed to guide your *unintentional injury prevention counseling.* A given answer may prompt you to address a safety issue or decide that a safety issue does not need to be discussed. However, the surveys and counseling guidelines do not address intentional injury prevention, psychosocial or family concerns, or other aspects of child development.

NOTE: The physician copy of the survey also should be added to the patient record to document the counseling and/or follow-up on certain issues at a later date.

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# COUNSELING GUIDELINES

## The First Year of Life

| HOUSEHOLD HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **1.** Do you put the crib side up whenever you leave your baby in the crib? | **Keep crib sides raised.** Crib sides need to be kept up and firmly secured to prevent falls. Even if your baby currently can't roll over or pull up, there's always a first time. |
| **2.** Do you leave the baby alone on tables or beds, even for a brief moment? | **If you leave, even for a moment, place your baby in a playpen or a crib with the sides up.** Emphasize the necessity of anticipating developmental stages; the baby's first rollover should not lead to a fall. |
| **3.** Do you leave the baby alone at home? | **Provide constant supervision.** Never leave your baby alone in the home without a capable baby-sitter, at least 13 years old, who can respond to emergency situations. Poisonings may occur in a matter of minutes; choking, falls, fires, and similar emergencies require immediate attention. |
| **4.** Do you keep plastic wrappers, plastic bags, and balloons away from your children? | **Keep plastic bags and balloons away from your children.** Plastic wrappers and bags form a tight seal if placed over the nose and mouth. Balloons can be inhaled into the windpipe and may cause death from choking. |
| **5.** Does your child wear a pacifier or jewelry around his or her neck? | **Do not put anything around a baby's neck—objects around the neck may strangle the baby.** Necklaces, ribbons, or strings around a baby's neck may get caught on parts of furniture or other objects and cause strangulation. Drawstrings also should be removed from all children's clothing. |
| **6.** Does your child play with small objects such as beads or nuts? | **Do not allow your child to play with small objects.** Any small objects that can be placed in the mouth (including plant parts) are potential hazards. Even small pieces of food may cause problems; children should not run or play while eating. Parents should be informed about emergency treatment for the choking child. Use the American Academy of Pediatrics (AAP) brochure *Choking Prevention and First Aid for Infants and Children.* Round or cylindrical food or objects are especially hazardous. |
| **7.** Are any of your baby-sitters younger than 13 years? | **Select an experienced baby-sitter.** All sitters should be at least 13 years old and mature enough to handle common emergencies. Use the TIPP Safety Slip *Baby-sitting Reminders.* |
| **8.** How frequently is the heating system checked where you live? | **Check heating systems and fireplaces at least once a year.** This annual inspection helps prevent carbon monoxide poisoning, fires, and system malfunction. |
| **9.** Are your operable window guards in place? | **Place operable window guards on all windows in your home.** Window guards should be well repaired and inspected regularly. Keep furniture away from windows that can give a climbing toddler access to a window sill. Apartment windows should have guards above the second floor. The spaces above and below window guards should be less than 4 inches to prevent a child from falling through. Children leaning on screens can fall through and be seriously injured. |
| **10.** Do you ever place your baby in an infant walker? | **Do not place your child in a walker.** Every year, more than 8,000 injuries occur to children in walkers. |

| BURNS | COUNSELING GUIDELINES |
|---|---|
| **11.** Does anyone in your home ever smoke? | **About one third of home fires involving fatalities are caused by smoking.** Smoking in bed or improper disposal of ashes or butts endangers children sleeping in adjacent rooms who may be trapped in the event of fire. |
| **12.** Do you have a plan for escape from your home in the event of a fire? | **Develop an escape plan in the event of a fire in the home.** Identify appropriate exit routes and a family meeting point away from the house. |
| **13.** Do you have working fire extinguishers in your home? | **Buy a fire extinguisher for the home.** The most common causes of home fires are cooking and heating equipment. Multipurpose dry chemical extinguishers should be available in the kitchen and in any room with a furnace or fireplace. |
| **14.** Do you have working smoke alarms in your home? | **Install smoke alarms in your home.** Most fire-related deaths occur at night and are the result of inhaling smoke or toxic gas. There is a critical period of 4 minutes to get outside after the alarm sounds. Smoke alarms are recommended for each floor, but particularly for furnace and sleeping areas. Alarms should be checked monthly. It is best to use smoke alarms that use long-life batteries, but if you do not, change the batteries at least once a year. |
| **15.** Do you ever drink or carry hot liquids when holding your baby? | **Do not drink or carry hot liquids when holding your child or when children are nearby.** Scalds result from spilled hot food and drink; scalding injuries can be decreased by avoiding use of tablecloths and keeping cups and saucers from the edge of tables. |
| **16.** Do you ever use woodstoves or kerosene heaters? | **Erect barriers around space heaters.** The use of space heaters, woodstoves, and kerosene heaters has been associated with severe burns to toddlers. Appropriate barriers should protect children. |

| WATER SAFETY | COUNSELING GUIDELINES |
|---|---|
| **17.** Do you leave the baby alone in or near a tub, pail of water, or toilet, even for a brief moment? | **Never leave a child alone in or near a tub, pail, toilet, or pool of water.** The bathtub is a source of severe scalding burns. If the phone or doorbell rings, don't leave an infant or toddler alone or with another child even for a moment. Baby bath seats are not safety devices and are not substitutes for adult supervision. Young children can drown in less than 2 inches of water. |
| **18.** Do you have a pool or hot tub where you live? | **Fence in your pool or hot tub on all 4 sides.** Nationally, drowning is the third leading cause of injury-related death in children younger than 1 year. Four-sided fencing is the only scientifically proven way to prevent drownings in pools and hot tubs. |

| AUTO SAFETY | COUNSELING GUIDELINES |
|---|---|
| **19.** Do you use a car safety seat in the car on every trip at all times? | **Your child should ride in a car safety seat during every trip, even if you will only be traveling a short distance.** |
| **20.** Does your car have a passenger air bag? | **NEVER place an infant in front of an air bag.** |
| **21.** Where do you place your child's car safety seat in the car? | **Seat a child in the rear seat of the car.** This is the safest place in the car. Infants should ride facing the rear of the car until they are at least 1 year of age AND at least 20 pounds. |

| BICYCLE SAFETY | COUNSELING GUIDELINES |
|---|---|
| **22.** Does your child ride on your bicycle with you? | **Do not carry children younger than 12 months on bicycles.** Infants are too young to sit in a rear bike seat because they cannot yet sit well unsupported and their necks are not strong enough to support a helmet. Carrying children in backpacks or frontpacks is not recommended while bicycling. |

| FIREARM HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **23.** Is there a gun in your home or the home where your child plays or is cared for? | **Remove all guns from places children live and play.** More than 5,000 children and adolescents are killed by gunfire each year—injuries almost always inflicted by themselves, a sibling, or a friend. Handguns are especially dangerous. If you choose to keep a gun at home, store it unloaded in a locked place. Lock and store the ammunition in a separate place. |

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# COUNSELING GUIDELINES

## From 1 to 4 Years (Part 1)

| HOUSEHOLD HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **1.** Do you leave your child alone at home? | **Never leave small children alone in the home.** Parents should be aware of the child's rapid acquisition of new abilities. |
| **2.** Are any of your baby-sitters younger than 13 years? | **Select an experienced baby-sitter.** All sitters should be at least 13 years old and mature enough to understand parental instructions and handle common emergencies. Use the TIPP Safety Slip *Baby-sitting Reminders.* |
| **3.** Do you keep plastic wrappers, plastic bags, and balloons away from your children? | **Keep plastic bags and balloons out of reach.** Plastic wrappers and bags form a tight seal if placed over the mouth and nose and may suffocate the child. Balloons can be inhaled into the windpipe and may result in death from choking. |
| **4.** Do you know how to prevent your child from choking? | **Small objects and solid foods such as hot dogs, peanuts, grapes, carrots, or popcorn may block your child's airway.** Any small objects that can be placed in the mouth are potential hazards. Children should not run or play while eating. Parents should learn CPR and emergency treatment for the choking child. Use the AAP brochure *Choking Prevention and First Aid for Infants and Children.* |
| **5.** Do you have mechanical garage doors? | **Mechanical garage doors may crush a child.** Install only garage door openers with sensors. |
| **6.** Are your operable window guards in place? | **Place operable window guards on all windows in your home.** Window guards should be well repaired and inspected regularly. Keep furniture away from windows that can give a climbing toddler access to a window sill. Apartment windows should have guards above the second floor. Windows should not be able to open more than 4 inches to prevent a child from falling through. Children leaning on screens can fall through and be seriously injured. |
| **7.** Is your child in the yard while the lawn mower is in use? | **Keep small children out of the yard while the lawn mower is in use.** Potential injury results from the machine itself and from objects thrown by the blade. Children should not be passengers on ride-on mowers. |
| **8.** Do you place gates at the entrance to stairways (for children younger than 3 years)? | **Use gates on stairways.** Use gates at the top and bottom of entrances to stairways because young children can quickly crawl or climb up the stairs from the lower level. Accordion-style gates are hazardous and can trap the child's head, causing death. |
| **9.** Is your baby's crib near a window or a drapery covering? | **Place your baby's crib away from windows.** Cords from window blinds and draperies can strangle your child. Tie cords high and out of reach. |

| | |
|---|---|
| **10.** Do you check for safety hazards in the homes of friends or relatives where your child may play? | **Check for hazards in homes your child may visit.** Other homes, especially those with no children or older children, may pose particular hazards from poisonings, falls, pools, and guns. |
| **11.** Have any of your children ever had an injury requiring a visit to the doctor or hospital? | **Report any history of injuries to the pediatrician.** The pediatrician is able to explore the causes and discuss preventive measures. It has been shown that stressful family situations can be causally linked to repeated injuries in children (3 or more injuries within 12 months). Also note that once an ingestion has occurred, another incident is likely within a year. |

| FIREARM HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **12.** Is there a gun in your home or the home where your child plays or is cared for? | **Remove all guns from places children live and play.** More than 5,000 children and adolescents are killed by gunfire each year—injuries almost always inflicted by themselves, a sibling, or a friend. Handguns are especially dangerous. If you choose to keep a gun at home, store it unloaded in a locked place. Lock and store the bullets in a separate place, and make sure to hide the keys to the locked boxes. |

| POISONINGS | COUNSELING GUIDELINES |
|---|---|
| **13.** Do you keep household products, medicines (including acetaminophen and iron), and sharp objects out of the reach of your child and in locked cabinets? | **Keep medicines and hazardous products out of the sight and reach of children.** Household products, medicines, and sharp objects should be stored locked in high places out of the child's sight. Keep household products in their original containers and never in food or beverage containers. |
| **14.** Do you dispose of old medicines? | **Dispose of old medicines.** All old medications should be safely disposed of by flushing them down the toilet. |
| **15.** Do you have safety caps on all bottles of medicine? | **Purchase medicines with child-resistant safety caps.** Remember to securely replace the cap and store the medicine out of the child's reach. |
| **16.** Does your child chew on paint chips or window sills? | **Inspect walls for peeling paint.** Paint that is peeling and chipped or is on chewable surfaces is a potential lead hazard. Approximately 85% of all homes built in the United States before 1978 have lead-based paint in them. Housing built before the 1950s poses particular risk for exposure to lead. |
| **17.** Do you have the number of the Poison Help Line by your phone? | **Learn first aid for poisoning.** Parents should be advised about the appropriate action to take when harmful substances have been ingested, and they should be told not to make their children vomit. Instruct parents to dispose of syrup of ipecac by flushing it down the toilet. Give them the telephone number of the national Poison Help Line, 1-800-222-1222. |
| **18.** How frequently is the heating system checked where you live? | **Heating ventilation systems and fireplaces should be checked at least once a year.** This annual inspection helps prevent carbon monoxide poisoning, fires, and system malfunction. Carbon monoxide detectors also are available to provide an early warning before the deadly gas builds up to a dangerous level. |

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# COUNSELING GUIDELINES

## From 1 to 4 Years (Part 2)

| BURNS | COUNSELING GUIDELINES |
|---|---|
| **1.** Do you use electrical appliances in the bathroom? | **Do not leave electrical appliances within the reach of a child in the bathroom.** Electrical current hazards are increased by wetness. Appliances must be used with extreme caution in the presence of water. |
| **2.** Do you keep electrical appliances and cords out of your child's reach? | **Keep electrical cords out of a child's reach.** Mouth burns in children can result from chewing on the end of a live extension cord or on a poorly insulated wire. Cords should not be within reach of a child. |
| **3.** Do you keep matches and cigarette lighters out of the reach of your children? | **Keep matches and lighters out of the reach of children.** Annually, 5,600 fires are started by children younger than 5 years playing with matches and lighters. These fires cause 150 deaths per year. |
| **4.** Does anyone in your home ever smoke? | **Most deaths due to home fires are caused by smoking.** Smoking in bed or improper disposal of ashes or butts endangers children sleeping in adjacent rooms who may be trapped in the event of fire. Twelve percent of residential fires are associated with smoking. |
| **5.** Do you have a plan for escape from the home in the event of a fire? | **Develop an escape plan in the event of a fire in the home.** Identify appropriate exit routes and a family meeting point away from the house. Do not use elevators in apartment buildings if there is a fire. Ask your fire department for help in designing an escape plan. Use the TIPP Safety Slip *Protect Your Home Against Fire...Planning Saves Lives.* |
| **6.** Do you have working fire extinguishers in your home? | **Buy a fire extinguisher for your home.** The most common causes of home fires are cooking and heating equipment. Multipurpose dry chemical fire extinguishers should be available in the kitchen and in any room with a furnace or fireplace. |
| **7.** Do you have working smoke alarms in your home? | **Install smoke alarms in your home.** The majority of fire-related deaths occur at night and are the result of inhaling smoke or toxic gas. There is a critical period of 4 minutes to get outside after the alarm sounds. Smoke alarms are recommended for each floor, but particularly for furnace and sleeping areas. Check the alarms monthly. It is best to use smoke alarms that use long-life batteries, but if you do not, change the batteries at least once a year. |
| **8.** Have you checked the temperature of the hot water where you live? | **Check hot water temperature.** A third-degree burn can occur in only 6 seconds with a water temperature of 140°F. The temperature of your hot water should be no higher than 120°F. In many cases you can adjust your water heater. |
| **9.** Do you keep the handles of pots and pans on the stove out of the reach of children? | **Keep hot pots and pans out of the reach of children.** Scalds in the kitchen are common; pot handles should be turned inward from the edge of the stove and be out of your child's reach. The kitchen is the most dangerous room for children. Keep children out of the kitchen when you are cooking, or put them in a playpen or high chair to keep them secure. |

| WATER SAFETY | COUNSELING GUIDELINES |
|---|---|
| **10.** Do you leave your child alone in the bathtub? | **Don't leave your child alone in a tub, even for a moment.** The bathtub is a source of severe scalds and also poses a potential drowning hazard. If the telephone or doorbell rings, don't leave your child alone or in the care of another child, even for a moment. |
| **11.** Do you take your child on a boat? | **Always wear a Coast Guard-approved life jacket.** Everyone on the boat should wear a Coast Guard-approved life jacket. At least 1 adult swimmer should be present for each child who cannot swim. Use the TIPP Safety Slip *Life Jackets and Life Preservers*. |
| **12.** Do you have a pool or hot tub where you live? | **Fence in your pool or hot tub on all 4 sides.** Drowning is the second leading cause of injury-related death of children nationally in this age group. Four-sided fencing is the only scientifically proven way to prevent drownings in pools and hot tubs. |
| **13.** Do you allow your child to swim unsupervised? | **Do not let children swim without supervision.** Never—not even for a moment—leave your children alone or in the care of another child in wading or swimming pools, spas, or other open standing water. A supervising adult should be within an arm's reach—providing "touch supervision"—whenever young children are in or around water. |

| BICYCLE SAFETY | COUNSELING GUIDELINES |
|---|---|
| **14.** Does your child ride on your bicycle with you? | **Use an approved child carrier.** Infants too young to sit in a rear bike seat should never be carried on a bicycle. Children 1 to 4 years of age who can wear a helmet may ride in a rear-mounted seat. Use of backpacks or frontpacks is not recommended. Parents should avoid riding in busy streets. With small children, falls frequently result in head injuries. Children should always wear a helmet that meets Consumer Product Safety Commission (CPSC) or Snell Memorial Foundation standards. |

| AUTO SAFETY | COUNSELING GUIDELINES |
|---|---|
| **15.** How are your children restrained when they ride in a car? | **Children this age should always be properly restrained in a car safety seat. Select a car safety seat that fits your child's size and weight and that can be installed properly in your car.** Your child should ride rear-facing until she is at least a year old AND weighs at least 20 pounds; it is even better for her to ride rear-facing to the highest weight and/or height her car safety seat allows. Use the seat every time you are in the car. Your child should use a car safety seat with a harness until she reaches the seat's upper weight limit or her ears come to the top of the seat, and then she should use a belt-positioning booster seat. Adults wearing seat belts are effective role models. Use the AAP brochure *Car Safety Seats: A Guide for Families* for a list of car safety seats that meet federal standards. |
| **16.** Do you leave your child alone in the car? | **NEVER leave a child alone in a car.** Children and car keys should always be removed from the car and the car kept locked. In addition to the many dangers of leaving children alone in the car, death from excess heat may occur in warm weather in a closed car in a short time. |
| **17.** Where do you seat your children in the car? | **Seat a child in the rear seat of the car.** This is the safest place in the car. Never allow children to ride in the cargo area of a station wagon or truck. |
| **18.** Does your car have a passenger air bag? | **Never put children in front of passenger air bags.** |
| **19.** Do you lock the car doors before driving? | **Buckle up and lock up!** Before the car moves, all seat belts or child safety seats should be properly fastened and all doors should be locked. |
| **20.** Does your child play in the driveway or in or near the street? | **Young children should not play in driveways or near busy streets.** Parents should always walk behind the car before backing down a driveway. Children may not be seen in the rearview mirror and could be run over. |

| TOY SAFETY | COUNSELING GUIDELINES |
|---|---|
| **21.** Do you check your child's toys for safety hazards? | **Inspect toys for safety hazards.** Repair or discard broken toys. Inspect your child's toys for projectile and sharp parts or small detachable parts. Some toys may pose hazards from electric shock and burns. Toys intended for older children should not be accessible to toddlers and preschoolers. Follow age guidelines on toy packaging. |

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# COUNSELING GUIDELINES

## From 5 to 9 Years

| FIREARM HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **1.** Is there a gun in your home or the home where your child plays or is cared for? | **Do not keep guns in your home.** Guns, especially handguns, should be removed from the environments where children live and play. If firearms are in the home, they must be stored unloaded in a locked place and out of the reach of children, with the ammunition locked separately. Guns are frequently involved in unintentional shootings in this age group, and homicides and suicides also occur. Parents should ask if the homes where their child visits or is cared for have guns and how they are stored. |

| HOUSEHOLD HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **2.** Do you let your child operate a power lawn mower? | **Never let children this age operate a lawn mower or ride with you on one.** Potential injury results from the machine itself and from objects thrown by the blade. Ride-on mowers are not recreational vehicles. Refer to the TIPP Safety Slip *Lawn Mower Safety.* |
| **3.** Have any of your children ever had any injuries requiring a visit to the doctor or hospital? | **Report any history of injuries to the pediatrician.** The pediatrician is able to explore the causes and discuss preventive measures. It has been shown that stressful family situations can be causally linked to repeated injuries in children (3 or more injuries needing medical attention within 12 months). |
| **4.** How frequently is the heating system checked in your home? | **Heating ventilation systems and fireplaces should be checked at least once a year.** This annual inspection helps prevent carbon monoxide poisoning, fires, and system malfunction. |

| BURNS | COUNSELING GUIDELINES |
|---|---|
| **5.** Do you and your children know how to get out of your home safely in the event of a fire? | **Develop an escape plan in the event of a fire in the home.** Identify appropriate exit routes and a family meeting point away from the house. Do not use elevators in apartment buildings if there is a fire. Use the TIPP Safety Slip *Protect Your Home Against Fire...Planning Saves Lives.* |
| **6.** Does anyone in your home ever smoke? | **A third of deaths due to home fires are caused by smoking.** Smoking in bed or improper disposal of cigarette ashes or butts endangers children sleeping in adjacent rooms who may be trapped in the event of fire. Twelve percent of residential fires are associated with smoking. |
| **7.** Does your child play with matches or lighters? | **Do not let children play with fire.** Keep matches and lighters out of the sight and reach of children. They commonly ignite flammable materials, which may result in severe burns and house fires. |
| **8.** Do you have working fire extinguishers in your home? | **Buy a fire extinguisher for your home.** Extinguishers should be available in kitchens and in rooms with a furnace or fireplace. |
| **9.** Does your child play with firecrackers or sparklers? | **Do not let children play with fireworks.** Firecrackers and sparklers can cause serious burns and injuries and should not be played with by children. Bystanders often are seriously injured by fireworks as well. An estimated 10,000 injuries related to fireworks are reported annually to the US Consumer Product Safety Commission (CPSC). |

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|---|---|
| **10.** Do you have working smoke alarms in your home? | **Install smoke alarms in your home.** Most fire-related deaths are the result of inhaling smoke or toxic gas. There is a critical period of 4 minutes to get outside the home after the alarm sounds. Smoke alarms are recommended for each floor, but particularly for furnace and sleeping areas. Be sure to test the alarm monthly to be certain that it is working. It is best to use smoke alarms that use long-life batteries, but if you do not, change the batteries every year. |
| **WATER SAFETY** | **COUNSELING GUIDELINES** |
| **11.** Does your child know how to swim? | **Teach children how to swim.** Swimming is an important life skill that all children should acquire. However, even if children know how to swim, there are still hazards. They may not retain their swimming skills in an emergency; even competent young swimmers should not swim unsupervised. |
| **12.** Does your child know the rules of water and diving safety? | **Teach and enforce the rules of swimming and diving safety.** Drowning is the second most common cause of death in children of this age. Knowledge of swimming is not enough to prevent drowning. Children should swim in supervised areas only. The "buddy" system is desirable. Teach your child to always enter the water feet first. Use the TIPP Safety Slips *Life Jackets and Life Preservers, Pool Safety for Children,* and *Water Safety for Your School-aged Child.* |
| **13.** Does your child wear a life jacket when on a boat? | **Be sure your child wears a life jacket when on a boat.** Everyone on the boat should use a Coast Guard-approved life jacket. At least 1 adult swimmer should be present for each child who cannot swim. |
| **AUTO SAFETY** | **COUNSELING GUIDELINES** |
| **14.** Does your child use a booster seat or seat belt when riding in the car? | **A booster seat should be used on every trip by all children who have outgrown their car safety seats with harnesses (usually around 40 pounds) until the seat belt fits correctly (usually around 4 feet 9 inches tall or between 8 and 12 years old).** Seat belts should not be used until the lap belt can be worn low and flat on the hips and the shoulder belt can be worn across the shoulder rather than the face or neck. Shoulder belts should be installed in the back seats of cars that do not have them. |
| **15.** Does your car have a passenger air bag? | **Never seat a child in front of a passenger air bag.** |
| **PEDESTRIAN SAFETY** | **COUNSELING GUIDELINES** |
| **16.** Do your children cross the street by themselves? | **Teach your child pedestrian safety skills.** All children should learn safe street-crossing skills and should demonstrate those skills to the parent before supervision ends. Children will still require supervision when crossing the street. Parents often think their children are able to handle traffic safely by themselves, but most children don't have the skills to handle these risky situations until at least 10 years of age.<br><br>Parents should be reminded that children<br>• Often act before thinking and may not do what parents or drivers expect<br>• May assume that if they see the driver, the driver sees them<br>• Can't judge speed like adults<br>• Are shorter than adults and can't see over cars, bushes, and other objects<br>• Need a place to play away from cars and the street |
| **BICYCLE SAFETY** | **COUNSELING GUIDELINES** |
| **17.** Has your child learned about bicycle safety? | **Teach and enforce bicycle safety rules.** Bicycle crashes can result in serious injury and death. Children should not ride in the street at this age. They should ride on bike paths, in parks, or in protected areas. They should never ride after dark. Bicycles should be equipped with coaster brakes at this age because the child may not be developmentally ready to use hand brakes appropriately. Use the TIPP handout *Safe Bicycling Starts Early.* The size of the bicycle should be appropriate for the child. Use the TIPP handout *Choosing the Right Size Bicycle for Your Child.* |
| **18.** Does your child wear a helmet every time he or she rides a bike? | **Wear a bicycle helmet.** All children should wear a bicycle helmet approved by the CPSC. Parents should set an example by wearing helmets when they ride bikes as well. |

| RECREATIONAL SAFETY | COUNSELING GUIDELINES |
|---|---|
| **19.** Does your child participate in sports? | **Wear protective gear during sports.** Despite safety measures, such as protective padding and helmets, the risk of injury is present in all sports. Children should be made aware of the risks that go with the sports they play. The chance of injury becomes greater with the degree of contact in a sport. Football, wrestling, gymnastics, soccer, ice hockey, and track/running have the highest rates of injury. Lower leg (knee and ankle) injuries are the most common injuries in major sports. Children should not participate in boxing because of the high risk of brain damage. Many serious sports injuries could be prevented if players wore protective equipment, particularly head and eye protection. Parents should encourage the use of such gear and teach their children that wearing protective gear increases the long-term enjoyment of the sport. If your child uses a scooter, skateboard, or rollerblades, a helmet, knee and elbow pads, and wrist guards should be worn. Use the AAP brochure *Sports and Your Child.* |
| **20.** Does your child participate in horseback riding? | **All children should wear an approved equestrian helmet when riding a horse.** All horseback riding activities should be supervised by an adult. |

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# COUNSELING GUIDELINES

## From 10 to 12 Years

| FIREARM HAZARDS | COUNSELING GUIDELINES |
|---|---|
| **1.** Is there a gun in your home or any of your friends' homes? | **Do not play with guns!** More than 300 children die each year of unintentional gunshot wounds. BB guns and paint pellet guns often cause severe eye injuries. Air rifles are dangerous weapons that can kill. |

| BURNS | COUNSELING GUIDELINES |
|---|---|
| **2.** Do you have working smoke alarms in your home? | **Check to see that your home has smoke alarms.** Most fire-related deaths are the result of inhaling smoke or toxic gas. There is a critical period of 4 minutes to get outside the home after the alarm sounds. Smoke alarms are recommended for each floor, but particularly for furnace and sleeping areas. You should know appropriate exit routes and a family meeting point away from the house. |

| BICYCLE SAFETY | COUNSELING GUIDELINES |
|---|---|
| **3.** Do you ever ride with passengers on your bike? | **Never ride with passengers on your bike.** This may impair your stability and visibility and lead to an injury. |
| **4.** Do you wear a helmet when you ride your bike? | **Always wear a helmet when riding a bike.** This protects you from head injury. Use the TIPP handout *Safe Bicycling Starts Early.* |

| AUTO SAFETY | COUNSELING GUIDELINES |
|---|---|
| **5.** Do you wear a seat belt in the car? | **Buckle up.** Seat belts save lives and should be used by all children. Remind your parents to buckle up as well. |
| **6.** Do you ride in cars that have passenger air bags? | **Do not sit in front of a passenger air bag.** The safest place for children to ride is in the back seat. |
| **7.** Where do you sit in the car? | **The safest place for you to ride is in the back seat, buckled up.** |

| PEDESTRIAN SAFETY | COUNSELING GUIDELINES |
|---|---|
| **8.** When you want to cross the street, what is the first thing you should always do? | **Follow safety rules when crossing the street.**<br>• Always stop at the curb, roadside, or at the outside edge of a parked car.<br>• Always look left-right-left before entering the area of the road in which cars travel, even if a traffic light says "walk."<br>• If a car is coming, wait until it passes and look left-right-left again.<br>• Proceed to cross the street only when the road is clear. |

| WATER SAFETY | COUNSELING GUIDELINES |
|---|---|
| **9.** When playing near water (for example, rivers, ponds, lakes, oceans), is it OK to play alone? | **Never play near water without an adult nearby.** Even if children can swim, they should never play unsupervised near bodies of water into which they may fall because they may not retain their swimming skills in an emergency. Water conditions (rapids, tides) may overwhelm otherwise capable swimmers. |

| FARM SAFETY | COUNSELING GUIDELINES |
|---|---|
| **10.** Do you live or work on a farm? | **Farm equipment is very dangerous to children.** Parents may need to be counseled for this question. |

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# ADDITIONAL RESOURCES

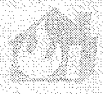
Because the American Academy of Pediatrics (AAP) has had a long-standing interest in injury prevention, a variety of materials has been published to enhance the pediatrician's effectiveness in injury prevention counseling for children of all ages.

The materials include a *First Aid Chart* for parents, *Car Safety Seats: A Guide for Families, Sports and Your Child, Choking Prevention and First Aid for Infants and Children,* and TIPP Safety Slips, which target very specific injury hazards. These materials have been well received and recently have been updated. They are useful supplements to TIPP. Currently available titles include

**AAP Safety Slips**

1. Baby-sitting Reminders
2. Infant Furniture: Cribs
3. Protect Your Child...Prevent Poisoning
4. Protect Your Home Against Fire... Planning Saves Lives
5. Safe Driving...A Parent's Responsibility
6. Safety Tips for Home Playground Equipment
7. Lawn Mower Safety
8. Home Water Hazards for Young Children
9. Water Safety for Your School-aged Child
10. Pool Safety for Children
11. Life Jackets and Life Preservers
12. Firearms Injury Prevention
13. When Your Child Needs Emergency Medical Services
14. Four Steps to Safety Readiness

In addition, the AAP has developed *Connected Kids: Safe, Strong, Secure*™ to address intentional injury prevention. Use the enclosed order form to order TIPP materials and any other available aids that you desire.



# COSGROVE EXHIBIT 3

PEDIATRICS®
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# Office-Based Counseling for Unintentional Injury Prevention

H. Garry Gardner

*Pediatrics* 2007;119;202
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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

CLINICAL REPORT

# Office-Based Counseling for Unintentional Injury Prevention

Guidance for the Clinician in Rendering Pediatric Care

H. Garry Gardner, MD, and the Committee on Injury, Violence, and Poison Prevention

ABSTRACT

Unintentional injuries are the leading cause of death for children older than 1 year. Pediatricians should include unintentional injury prevention as a major component of anticipatory guidance for infants, children, and adolescents. The content of injury-prevention counseling varies for infants, preschool-aged children, school-aged children, and adolescents. This report provides guidance on the content of unintentional injury-prevention counseling for each of those age groups.

## INTRODUCTION

Unintentional injuries continue to be the leading cause of death in children older than 1 year. In 2003, unintentional injuries caused 34.6% of all deaths in 1- to 4-year-olds, 37.8% of all deaths in 5- to 9-year-olds, 37.5% of all deaths in 10- to 14-year-olds, and 49.7% of all deaths in 15- to 19-year-olds. Among all children from 1 to 19 years of age, 64.7% of unintentional injury deaths involved motor vehicles.[1]

Pediatricians play a key role in educating parents about the risks of unintentional injuries and specific measures to minimize those risks, including environmental modification or the use of safety equipment. Anticipatory guidance is a major component of well-child care and injury visits, and parents value the advice and counseling they receive from their pediatricians. Anticipatory guidance for injury prevention should be an integral part of the medical care provided for all infants, children, and adolescents.

Counseling for the prevention of unintentional injuries needs to be appropriate for the child's age and locale. Initially, it is necessary for the counseling to be provided to the parent or caregiver as both the role model for the child's behavior and the person who is most capable of modifying the child's environment. As children mature, counseling should be directed increasingly toward children or adolescents as they become responsible for their own behavior. Physicians are encouraged to document injury-prevention counseling in the medical chart.

In 1983, the American Academy of Pediatrics introduced The Injury Prevention Program (TIPP). TIPP includes a safety-counseling schedule, age-appropriate safety surveys, and age-appropriate safety sheets for families to take home.[2] Physicians may use different parts of TIPP to supplement their anticipatory guidance.[2] The interventions outlined here and in TIPP have been shown to be effective in improving parental safety practices.[3–9] A review of the literature on childhood injury-prevention counseling in primary care settings demonstrated that 18 of 20 studies have shown positive outcomes in increasing knowledge and behavior and in decreasing injury rates in children.[10] A systematic review of 22 randomized,

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**Key Words**
injuries, prevention, anticipatory guidance, infants, children, adolescents

**Abbreviations**
TIPP—The Injury Prevention Program
ATV—all-terrain vehicle

controlled trials of counseling and other interventions in a clinical setting demonstrated improvement in certain safety practices, specifically motor vehicle restraint use, smoke alarm ownership, and maintenance of safe hot-water temperature.[11]

### INFANTS

Advise parents about the following issues:

1. Traffic safety: The correct use of currently approved child safety restraints needs to be discussed. The infant car safety seat should be rear-facing in the back seat, never in the front seat if there is a passenger-side air bag. Infants should never be left unattended in an automobile. Parents need to be reminded of the importance of using their own seat belts.[12]
2. Burn prevention: Smoke alarms in the home should be installed and maintained.[13,14] Hot-water temperature should be set at a maximum of 120°F to avoid scald burns. Parents should be advised not to carry their infant and hot liquids or foods at the same time. Milk and formula should not be heated in the microwave because it can heat unevenly, causing pockets of liquid hot enough to scald the infant's mouth. Electrical outlets should be covered with devices that will not pose a choking hazard.
3. Fall prevention: Window and stairway guards/gates are necessary to prevent falls from heights.[15] Infant walkers should not be used.[16] Infants should never be left alone on any furniture such as changing tables, beds, or sofas.
4. Choking prevention: Small parts or objects can pose a choking hazard to young children. Round or cylindrical and compressible objects and foods can pose life-threatening risks of airway obstruction. Balloons pose a similar risk for young children. To avoid risk of strangulation, parents should be advised to avoid clothes and toys with long strings and cords and to cut looped blind and drapery cords. Suffocation may occur from entrapment in unsafe crib environments and access to waterbeds or plastic bags. Parents should be aware of hazards in any home where an infant spends time.
5. Drowning prevention: Because very young infants drown most commonly in bathtubs and buckets while unsupervised, advise parents never to leave infants or young children in the bathtub or around other bodies of water without constant adult supervision, and advise them to empty and properly store buckets immediately after use.[17–19] Parents should be reminded that infant bath seats or supporting rings are not a substitute for adult supervision.
6. Safe sleep environment: Infants should be placed for sleep in a supine position in a crib that conforms to current safety standards. Infants should not be put to sleep on soft surfaces such as waterbeds or sofas. Avoid soft materials in the infant's sleep environment. If bumper pads are used, they should be removed when the infant begins to stand. Never leave the crib sides down when the infant is in the crib.[20]
7. Cardiopulmonary resuscitation: It is important that parents become trained in infant and child cardiopulmonary resuscitation and learn how to access their local emergency medical services (eg, 911).

### PRESCHOOL-AGED CHILDREN

Toddlers and young children are more able to explore their environment but do so with little regard to risk or consequences. Parents of preschool-aged children need to be counseled to take a proactive role in protecting their children.

1. Traffic safety: Toddlers may be placed in a forward-facing car safety seat when they reach 1 year and 20 pounds, but it is best for them to remain rear-facing until they reach the highest weight or height allowed in that position by the car safety seat. Preschool-aged children should always ride in the back seat. Parents need to be reminded again of the importance of using their own seat belts.[12] Young children should never be left unsupervised in or around cars. Driveways and streets are particularly dangerous places for children to play. Supervised pedestrian safety begins at this age. Preschool-aged children are not ready to cross the street alone. Children must be watched closely when near driveways and streets.[21] Use of an approved bicycle helmet begins with riding a tricycle or bicycle with training wheels.
2. Burn prevention: Smoke alarm batteries should be checked regularly.[22] Children should be kept away from hot oven doors, irons, wall heaters, and grills. Advise parents to keep hot food and coffee out of the reach of young children.[14] Electrical outlets should be covered.
3. Fall prevention: Toddlers learning to walk and climb need to be protected from stairways, open windows, and heavy furniture that could topple over.[15]
4. Poison prevention: Medicines and household products should be kept out of the sight and reach of children and locked up whenever possible. These items should be purchased and kept in original child-proof containers or blister packs. Ipecac is no longer recommended and, if present in the home, should be discarded. Keep the poison control telephone number (1-800-222-1222) handy.[23]
5. Drowning prevention: Backyard swimming pools or spas need to be completely fenced on 4 sides to separate them from the house and yard; the fence should

have a self-closing, self-latching gate.[24] The gate should open away from the pool and should be checked often to ensure that it is in good working order. Children younger than 5 years should swim only with close adult "touch" supervision.[17–19]

6. Firearm safety: Because of the dangers that in-home firearms, particularly handguns, pose to young children, parents should be advised to keep handguns out of places where children live and play. If parents choose to keep a firearm in the home, the unloaded gun and ammunition must be kept in separate locked cabinets.[25]

### SCHOOL-AGED CHILDREN

Advice to parents of elementary school–aged children begins to be more focused on the child's behavior. Children begin to learn home safety rules by 3 to 4 years of age.[26] The child should then be included in this learning process, and the parents should be reminded again of their need to model safe behaviors.

1. Traffic safety: When children reach the top weight or height allowed for their car safety seat, they need to ride in booster seats. A booster seat should be used until the child properly fits in the adult seat belt with the shoulder belt lying across the chest, the lap belt low and snug across the upper thighs, and the legs bent at the knees when sitting against the vehicle seat back (usually around 4 feet 9 inches in height and between 8 and 12 years of age).[12] Remind children and parents that no one should ride in the bed of a pickup truck.[27] All-terrain vehicles (ATVs) should not be used by children younger than 16 years.[28,29] Review safe pedestrian practices.[21] Approved bicycle helmets should be worn on every bike ride.[30,31]
2. Water safety: Children 5 years and older should be taught to swim and should be taught appropriate rules for water play. Children must never be allowed to swim alone. Coast Guard–approved personal flotation devices should be worn by all children engaged in any boating activity.[17]
3. Sports safety: Adults who supervise children participating in organized sports programs and recreational activities need to emphasize the importance of safety equipment for the particular sport as well as appropriate physical conditioning for that sport.[32–35] The use of protective equipment for in-line skating and skateboarding needs emphasis.[36,37]
4. Firearm safety: In addition to removing firearms from the home environment where children explore and play, it is important for parents to ask whether there is a gun in any home that their child visits. If parents choose to keep a firearm in the home, the unloaded gun and ammunition must be kept in separate locked cabinets.[25]

### ADOLESCENTS

Injury-prevention advice to adolescents ideally is included in a broader discussion of healthy lifestyle choices, especially the avoidance of alcohol, tobacco, or other drug use. It is important for pediatricians, parents, and schools to remain united in their efforts to promote community choices that, by modifying the adolescent environment, make adolescent risk-taking less likely to occur, thus decreasing the risk of significant injury. Specific areas of injury-prevention guidance include the following:

1. Traffic safety: Encourage seat belt use and discuss the role of alcohol and drugs in teenage motor vehicle crashes. Discuss specific ways to minimize distracted driving, including eating, drinking, and especially using a cellular phone or electronic device while driving. Alert parents and adolescents to the dangers of high-risk situations, including speeding and reckless driving. Encourage compliance with graduated driver-licensing laws. Parents should enact strict rules to limit nighttime driving and the number of passengers in the car.[38] A helmet should be worn whenever riding a bicycle, motorcycle, or ATV.[28,30] ATVs should not be used by children younger than 16 years.[28]
2. Water safety: Discuss the risks of swimming in remote locations and at sites that are not designated as swim areas as well as the dangers of alcohol and other drug consumption during aquatic recreation activities (eg, swimming, diving, boating). The first entry into any body of water should be feet first, and it is important to know the water's depth and the location of any underwater hazards before jumping or diving. Discuss the need to use an approved personal flotation device whenever the child is riding on a boat or other watercraft or fishing.[17]
3. Sports safety: Adolescents participating in organized sports programs and recreational activities need to be reminded of the importance of safety equipment, including protective eyewear, for their particular sport as well as appropriate physical conditioning for that sport.[32–35] The importance of using protective equipment for in-line skating and skateboarding needs emphasis.[36,37]
4. Firearm safety: In-home firearms are particularly dangerous during adolescence because of the potential for impulsive, unplanned use by teens resulting in suicide, homicide, or serious unintentional injuries. Firearms, and especially handguns, should be kept out of the home. If parents choose to keep a firearm in the home, the unloaded gun and ammunition must be kept in separate locked cabinets. Parents should ask whether there is a gun in any home that teenagers visit.[25]

## CONCLUSIONS

Injury-prevention counseling should be integrated into every well-child visit. Because of time constraints, specific topics could be addressed at different visits and tailored to be appropriate for the season, the child's activities, and concerns and questions raised by the parent. The topics addressed should be documented in the medical record. TIPP information sheets could be attached to vaccine information sheets on each visit. Telephone numbers (eg, poison control center) and Web sites could be posted in the waiting room along with brochures and posters. Parents and children are often receptive to injury-prevention counseling during a sick visit, especially if it is related to an injury, a recent emergency department visit, or injury to a sibling.[39] Finally, pediatricians can be more effective advocates for injury prevention by working with community resources that have a major influence on children,[11] such as the school system, park district, Head Start, child care centers, organizations such as the YMCA, and local media.



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# Office-Based Counseling for Unintentional Injury Prevention

H. Garry Gardner

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# COSGROVE EXHIBIT 4

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**Table 30-2** Haddon's Matrix and Examples of Variables and Injury Prevention Interventions

| | EPIDEMIOLOGIC DIMENSION | | | |
|---|---|---|---|---|
| **PHASE** | **HUMAN** | **VECTOR OR VEHICLE** | **PHYSICAL ENVIRONMENT** | **SOCIOECONOMIC ENVIRONMENT** |
| Preevent | Judgment<br>Coordination | Safe storage of firearms<br>Infant walker ban | Bicycle paths<br>Swimming pool barriers | Speed limits<br>Graduated driver licensing |
| Event | Car safety seat use<br>Use of protective equipment | Airbags<br>Energy-absorbing surfacing on playgrounds | Smoke alarms<br>Highway guard rails | Helmet laws<br>Enforcement of seat belt laws |
| Postevent | Age<br>Physical condition | Activated charcoal<br>Fuel system integrity | Time to emergency treatment<br>Availability of rehabilitation programs | Training of emergency medical system personnel<br>Cardiopulmonary resuscitation training |

Adapted from American Academy of Pediatrics, Committee on Injury and Poison Prevention. *Injury Prevention and Control for Children and Youth.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 1997; and PediaLink continuing medical education course, Moving Kids Safely: Introduction to Car Safety Seats.

appropriate action or not. Airbags are a good example. Both active and passive strategies can be quite successful when used, but passive strategies, when they exist, are usually favored over active strategies. Active strategies require compliance, and a risk always exists that they will not be fully used. Active strategies are often least likely to be adopted by the persons at greatest risk.

### Education, Engineering, and Enforcement

Another framework for categorizing injury-prevention measures is the *3 Es*. Education is the approach that is most familiar to health professionals; examples include counseling during health supervision visits and public education campaigns. Engineering involves modifying a hazard or the environment to prevent injuries or reduce the severity of injuries. Enactment and enforcement of legislation and regulation can motivate people to adopt safety-promoting behaviors, require environmental modifications to reduce hazards, and facilitate changes in social norms. Injury prevention is usually most effective when all 3 approaches are incorporated. For example, bicycle helmet use can be promoted through education in schools, design of more comfortable or attractive helmets, and local laws or ordinances requiring helmet use.

### Intentional Versus Unintentional Injuries

Injuries are often classified as unintentional or intentional. This dichotomy is useful in many ways; however, the intent of human behavior is not always clear cut and is better described as a continuum. For example, should injuries that result in part from inadequate parental supervision be considered unintentional or intentional resulting from child neglect? Additionally, strategies that prevent unintentional injury (eg, locking up firearms, turning down the water heater temperature) may also prevent some intentional injuries. For these reasons, and because injuries result from both, injury-control efforts often address both intentional and unintentional injury. Nevertheless, some forms of intentional injury, for example, child abuse and child and adolescent suicide and homicide, are so important as causes of pediatric morbidity and mortality that they demand focused attention. Furthermore, the causes of intentional injury are extremely complex, and violence-prevention efforts must take a multifaceted approach that includes the pediatrician. The pediatrician's important role in violence prevention is discussed in Chapter 31, Violence Prevention.

### Pediatrician Roles

Pediatricians can attempt to persuade individuals to decrease their risk of injury through educational efforts with individuals or groups. Injury-control advocates have additional strategies at their disposal. Pediatricians can be involved in many of these activities, including media campaigns, legislation, regulation, litigation, environmental design, and cultural change. For most causes of injury, multiple strategies will need to be applied. The pediatrician can also become involved in research to identify risk and protective factors for injury and to evaluate prevention interventions.

## ANTICIPATORY GUIDANCE

Evidence of positive outcomes after injury-prevention counseling in clinical practice was identified by a structured review of the literature.[1] The evidence for the effectiveness of injury-prevention counseling is stronger in some areas than it is in others, prompting continual calls for additional research, improvements in counseling, and investment in more passive injury-control strategies. For example, the redesign of baby walkers resulted in a dramatic decrease in injuries associated with falls down stairs in this product, demonstrating the

**BOX 30-1 Topics Recommended by the American Academy of Pediatrics for Office-Based Unintentional Injury-Prevention Counseling**

**INFANTS**

- Traffic safety: Appropriate use of car safety seats rear-facing in the back seat
- Burn prevention: Smoke alarms, hot water temperature no higher than 120°F
- Fall prevention: Window and stairway guards and gates, avoiding walker use
- Choking and strangulation prevention: Keeping small objects and balloons or plastic bags away from infants, blind and drapery cord safety
- Drowning prevention: Supervising baths, emptying buckets
- Safe sleep environment: Back to sleep in a crib that meets current safety standards
- CPR training: Parent knowledge of infant or child CPR and local emergency medical services (911)

**PRESCHOOLERS**

- Traffic safety: Appropriate use of car safety seats, not leaving children unsupervised in or around cars
- Burn prevention: Smoke alarm batteries; keeping children away from hot objects
- Fall prevention: Window and stairway guards and gates; preventing furniture tip-overs
- Poison prevention: Storage of poisons; poison control phone number (1-800-222-1222)
- Drowning prevention: Pool fencing; *touch supervision*
- Firearm safety: Preferably keeping firearms out of the home or at least keeping firearms unloaded and locked separately from locked ammunition

**SCHOOL-AGED CHILDREN**

- Traffic safety: Booster seat and seat belt use, avoiding riding on ATVs and in the beds of pickup trucks; safe pedestrian practices; helmets for biking
- Water safety: Swimming lessons, but no swimming alone; personal flotation devices for boating
- Sports safety: Safety equipment, physical conditioning, and protective equipment for rollerblading and skateboarding
- Firearm safety: Preferably keeping firearms out of the home or at least keeping firearms unloaded and locked separately from locked ammunition; asking about firearms in other homes the child visits

**ADOLESCENTS**

- Traffic safety: Seat belt use, role of alcohol in motor vehicle crashes, and minimizing distracted driving; graduated driver licensing; rules for teenage drivers; helmets for biking, motorcycling, and riding an ATV
- Water safety: Role of alcohol and other drugs in water-related injuries; personal flotation devices for boating
- Sports safety: Safety equipment; physical conditioning
- Firearm safety: Preferably keeping any firearms out of the home or at least unloaded and locked separately from locked ammunition

*ATV*, All-terrain vehicle; *CPR*, cardiopulmonary resuscitation.
Modified from American Academy of Pediatrics, Committee on Injury, Violence, and Poison Prevention. Office-based counseling for unintentional injury prevention. *Pediatrics*. 2007;119:202-206.

effectiveness of the passive prevention approach after years of unsuccessful anticipatory guidance and the use of warning labels.[2]

Even though injury-prevention counseling has become a cornerstone of pediatric practice, it can be daunting, not only because of the time and expertise it requires, but also because of its breadth. Injury risk is so universal and the sources of possible injury so diverse that a pediatrician cannot counsel on all possible risks. Injury-prevention topics can be prioritized based on severity of the injury, frequency with which the injury occurs, and the availability of effective preventive strategies. Pediatricians will want to be sensitive to the individual circumstances of patients and families as well. For instance, farm families may need advice that city families do not, and vice versa. Knowing that a family has a boat or a backyard swimming pool prompts a special discussion of drowning risk. In another example of the need to customize anticipatory guidance, counseling a family that has 2 automobiles about car safety seats poses a different set of issues than does counseling a family that relies on taxis for transportation; yet child passenger safety is a high priority for both.

The American Academy of Pediatrics (AAP) recommends that parents be given advice by the pediatrician about various injury issues, depending on the age of the child (Box 30-1).[3] The AAP also provides several tools to facilitate counseling, including age-specific survey instruments to assess risk and handouts for families, as part of TIPP—The Injury Prevention Program.[4] (The counterpart AAP program for intentional injury prevention is Connected Kids: Safe, Strong, Secure, as described in Chapter 31, Violence Prevention.)

Counseling about any injury-prevention topic requires both knowledge and counseling skill. In addition to TIPP materials, several resources are listed at the end of this chapter that can provide a pediatrician with the knowledge for advising parents (and communities) about injury prevention. Counseling technique is not specific to injury prevention but can be adapted from existing methods for prompting and supporting healthy behavior change (eg, motivational interviewing). Counseling techniques that include motivational interviewing are addressed in Chapter 24, Communication Strategies.

## Traffic Safety

### *Car Safety Seats*

Because motor vehicle crashes are the leading cause of death of children and adolescents, the topic warrants frequent discussion during well-child care. Use

**Table 30-3** Appropriate Car Safety Seat Selection Based on Child's Age, Height, and Weight

| IF THE CHILD IS | USE THE FOLLOWING TYPE OF CAR SAFETY SEAT | AND REMEMBER THE FOLLOWING |
|---|---|---|
| Younger than 1 year OR under 20 lb | Rear-facing car safety seat (infant-only or convertible) | NEVER place a rear-facing car safety seat in the front seat with an airbag. |
| Older than 1 year AND over 20 lb | Recommended: rear-facing convertible seat to seat's height or weight (usually 30 or 35 lb) limit<br>Then: forward-facing car safety seat (convertible, combination, or forward-facing only) to seat's height or weight limit | When switching a convertible seat from rear-facing to forward-facing, adjustments are usually needed to the harness, the angle of the seat, and the seat belt. |
| Too tall or heavy for a forward-facing seat with a harness (often around 4 years of age or 40 lb)<br>Big enough to fit in the adult seat belt (usually around 4' 9" and between 8 and 12 years of age) | Booster seat<br><br>None. Use the vehicle's seat belt if it fits properly (shoulder belt across chest and shoulder, lap belt low and snug on thighs, child's back against vehicle seat back and knees bent at edge of vehicle seat). | Booster seats must be used with lap and shoulder belts.<br><br>Children should sit in the back seat until they turn 13 years of age. |

Adapted from American Academy of Pediatrics, Committee on Injury and Poison Prevention. Selecting and using the most appropriate car safety seats for growing children: guidelines for counseling parents. *Pediatrics.* 2002;109:550-553.

of car safety seats is a complex issue that pediatricians should not expect to master fully. Rather, pediatricians should know how to counsel parents on appropriate car safety seat selection based on developmental milestones (age, height, weight, and behavior) and where to refer parents for more information. When counseling on car safety seat selection, pediatricians should be familiar with state laws. However, recognizing that state laws often do not reflect best practice in car safety seat use is important. Table 30-3 provides information about car safety seat selection. Parents should be encouraged to read the instruction manuals for their car safety seats and vehicles to learn how to install and use car safety seats. For more information, parents can be referred to local *child passenger safety technicians*; a pediatric practice may even choose to have a staff member complete the 3- to 4-day training course to become a certified technician.

### *Counseling Teen Drivers*

Counseling on motor vehicle safety remains important even after children have outgrown car safety seats. In fact, such counseling may be more important because motor vehicle–related death rates increase dramatically in adolescence, and novice teen drivers and their passengers are at particularly high risk. The pediatrician can play a key role in helping parents and teens negotiate their changing relationship, balancing the need to ensure the teen's safety with the teen's growing independence and increasing mobility. A state's graduated driver licensing (GDL) system may provide a good starting point for counseling, and pediatricians should be familiar with their states' laws. Under GDL, teen drivers graduate from a learner's permit to an intermediate or provisional license to a regular driver's license after spending a required amount of time and after demonstrating proficiency in a lower stage; each stage has its own restrictions. However, because many states' GDL laws are relatively weak and a few states do not have GDL laws, parents should be counseled about additional restrictions (eg, limits on the number of teenage passengers, limits on nighttime driving) that they should place on novice teen drivers. Parents and teens both should be counseled on seat belt use and the dangers of impaired driving. They should also be encouraged to have a safe ride agreement, whereby the teen promises to call the parent rather than driving while impaired or with another impaired driver and the parent agrees to provide a ride home in a nonjudgmental way. Pediatricians can consider having a family develop a parent-teen driving contract that specifies restrictions on teen drivers, when the restrictions will be relaxed, and the consequences for violating the restrictions.

### Firearms

Because firearms-related injuries (unintentional and intentional) are the 2nd leading cause of death of children and adolescents, firearms are an important topic on which to provide anticipatory guidance.[5] Pediatricians are often reluctant to counsel on this topic, and parents may view such counseling as intrusive or outside the purview of pediatrics. Fortunately, strategies are available that can make counseling on firearms more palatable to both parents and pediatricians. For families with infants and toddlers, firearms can be discussed in the context of childproofing and children's

natural curiosity. For parents of depressed adolescents, the association between presence of firearms in the home and higher risk of teen suicide can be discussed. Especially for parents who are receptive to firearm injury-prevention counseling, the pediatrician can introduce the concept of asking about the presence of guns in other homes where their children spend time.

## TOOLS FOR PRACTICE

### Community Advocacy and Coordination

- *Child Passenger Safety Issue Brief*, American Academy of Pediatrics (www.aap.org/securemoc/statelegislation/boosterseats_issuebrief.pdf).
- Injury Free Coalition for Kids (www.injuryfree.org/).
- Insurance Institute for Highway Safety (www.iihs.org/).
- *National Center for Injury Prevention and Control* (Web page), Centers for Disease Control and Prevention (www.cdc.gov/ncipc/).
- National Highway Traffic Safety Administration (hotline), 1-800-424-9393; (www.nhtsa.gov).
- National Poison Control Number (hotline), 1-800-222-1222; (www.edisonnj.gov).
- *Reducing the Burden of Injury: Advancing Prevention and Treatment* (book), Institute of Medicine (www.iom.edu/cms/3793/5627.aspx).
- Safe Kids Worldwide (www.safekids.org).
- *Safety and First Aid* (Web page), American Academy of Pediatrics (www.aap.org/healthtopics/safety.cfm).
- Seat Check (www.seatcheck.org/).
- *Teen Driving Issue Brief* (report), American Academy of Pediatrics (www.aap.org/securemoc/statelegislation/gdl_issuebrief.pdf).
- *Transportation Safety* (Web page), American Academy of Pediatrics (www.aap.org/healthtopics/carseatsafety.cfm).
- US Consumer Product Safety Commission, 800-638-2772.
- *Water Safety* (Web page), American Academy of Pediatrics (www.aap.org/healthtopics/watersafety.cfm).
- *WISQARS™*, Web-Based Injury Statistics Query and Reporting System (on-line database), Centers for Disease Control and Prevention (www.cdc.gov/ncipc/wisqars/).

### Engaging Patient and Family

- *A Parent's Guide to Water Safety* (brochure), American Academy of Pediatrics (patiented.aap.org).
- *Air Bag Safety* (fact sheet), American Academy of Pediatrics (www.aap.org/bookstore).
- Asking Saves Kids Campaign (ASK) (www.paxusa.org/ask/index.html).
- *Baby Walkers* (fact sheet), American Academy of Pediatrics and National Association of Children's Hospitals and Related Institutions (www.aap.org/bookstore).
- *Car Safety Seats: A Guide for Families* 2007 (brochure), American Academy of Pediatrics (patiented.aap.org).
- *Choking Prevention and First Aid for Infants and Children* (brochure), American Academy of Pediatrics (patiented.aap.org).
- *Home Safety Checklist* (fact sheet), American Academy of Pediatrics (www.aap.org/bookstore).
- *Keep Your Family Safe: Fire Safety and Burn Prevention at Home* (brochure), American Academy of Pediatrics (patiented.aap.org).
- *Parent-Teen Driving Agreement and Fact Sheet* (fact sheet), American Academy of Pediatrics (www.aap.org/bookstore).
- *One-Minute Car Safety Seat Check-up* (fact sheet), American Academy of Pediatrics (patiented.aap.org).
- *Partners for Child Passenger Safety* (Web page), Children's Hospital of Philadelphia (www.chop.edu/consumer/jsp/division/generic.jsp?id=77971).
- *Protect Your Child From Poison* (brochure), American Academy of Pediatrics (patiented.aap.org).
- Seat Check (www.seatcheck.org).
- *The Injury Prevention Program (TIPP)*, American Academy of Pediatrics (www.aap.org/family/tippmain.htm).
- *Toy Safety* (brochure), American Academy of Pediatrics (patiented.aap.org).
- *Trampolines* (fact sheet), American Academy of Pediatrics (www.aap.org/bookstore).

### Medical Decision Support

- *Anticipatory Guideline Topics for Car Seat Safety* (fact sheet), American Academy of Pediatrics (pediatrics.aap.org/content.aspx?aid=2001).
- *Car Seat Selection Based on Child's Age, Height, and Weight* (fact sheet), American Academy of Pediatrics (pediatrics.aap.org/content.aspx?aid=2001).
- *TIPP—Guide to Safety Counseling in Office Practice* (booklet), American Academy of Pediatrics (www.aap.org/family/tippguide.pdf).
- *TIPP Safety Program*, American Academy of Pediatrics (www.aap.org/bookstore).
- *TIPP and Connected Kids on CD-ROM: Injury and Violence Prevention Counseling Resources* (CD-ROM), American Academy of Pediatrics (www.aap.org/bookstore).

## AAP POLICY STATEMENTS

American Academy of Pediatrics, Committee on Injury and Poison Prevention. Selecting and using the most appropriate car safety seats for growing children: guidelines for counseling parents. *Pediatrics*. 2002;109(3):550-553. (aappolicy.aappublications.org/cgi/content/full/pediatrics;109/3/550).

American Academy of Pediatrics, Committee on Injury and Poison Prevention. Firearm-related injuries affecting the pediatric population. *Pediatrics*. 2000;105(4):888-895. (aappolicy.aappublications.org/cgi/content/full/pediatrics;105/4/888).

American Academy of Pediatrics, Committee on Injury, Violence, and Poison Prevention. Office-based counseling for unintentional injury prevention. *Pediatrics*. 2007;119(1):202-206. (aappolicy.aappublications.org/cgi/content/full/pediatrics;119/1/202).

American Academy of Pediatrics, Committee on Injury, Violence, and Poison Prevention, Committee on Adolescence. The teen driver. *Pediatrics*. 2006;118:2570-2581.

For a complete list of all policy statements from the American Academy of Pediatrics, Committee on Injury, Violence, and Poison Prevention visit: aappolicy.aappublications.org/cgi/collection/committee_on_injury_violence_and_poison_prevention.