

Editor's key points

► The 2020 edition of the Rourke Baby Record (RBR) is an update of the 2017 edition and provides updated recommendations for the primary care of children younger than 6 years of age. The knowledge translation tools and supporting literature are available at www.rourkebabyrecord.ca.

► Important revisions include the recommendations to limit or avoid consumption of highly processed foods high in dietary sodium, to ensure safe sleep (healthy infants should sleep on their backs and on a firm surface for every sleep, and should sleep in a crib, cradle, or bassinette in the parents' room for the first 6 months of life), to not swaddle infants after they attempt to roll, to inquire about food insecurity, to encourage parents to read and sing to infants and children, to limit screen time for children younger than 2 years of age (although it is accepted for videocalling), to educate parents on risks and harms associated with e-cigarettes and cannabis, to avoid pesticide use, to wash all fruits and vegetables that cannot be peeled, to be aware of the new Canadian Caries Risk Assessment Tool, to note new red flags for cerebral palsy and neurodevelopmental problems, and to pay attention to updated high-risk groups for lead and anemia screening.

► The 2020 edition of the RBR was completed before the onset of the coronavirus disease 2019 pandemic, and thus does not include recommendations regarding virtual care. The RBR will continue to find ways to support primary care providers within the shifting landscape of health care delivery.

2020 edition of the Rourke Baby Record

What is new in preventive care of children up to 5 years of age?

Patricia Li MD MSc FRCPC FAAP Anne Rowan-Legg MD FRCPC Bruce Kwok MD MSc CCFP
Imaan Bayoumi MD MSc FCFP Stephani Arulthas MPH Emmanuela Tedone MEd
Denis Leduc MD CCFP FRCPC FAAP James Rourke MD MCISc(FM) FCFP(EM) FCAHS
Leslie Rourke MD MCISc(FM) FCFP FRRMS

Abstract

Objective To update primary care providers practising well-child and well-baby clinical care on the evidence that contributed to the recommendations of the 2020 edition of the Rourke Baby Record (RBR).

Quality of evidence Pediatric preventive care literature was searched from June 2016 to May 2019, primary research studies were reviewed and critically appraised using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology, and recommendations were updated where there was support from the literature.

Main message Notable changes in the 2020 edition of the RBR include the recommendations to limit or avoid consumption of highly processed foods high in dietary sodium, to ensure safe sleep (healthy infants should sleep on their backs and on a firm surface for every sleep, and should sleep in a crib, cradle, or bassinette in the parents' room for the first 6 months of life), to not swaddle infants after they attempt to roll, to inquire about food insecurity, to encourage parents to read and sing to infants and children, to limit screen time for children younger than 2 years of age (although it is accepted for videocalling), to educate parents on risks and harms associated with e-cigarettes and cannabis, to avoid pesticide use, to wash all fruits and vegetables that cannot be peeled, to be aware of the new Canadian Caries Risk Assessment Tool, to note new red flags for cerebral palsy and neurodevelopmental problems, and to pay attention to updated high-risk groups for lead and anemia screening.

Conclusion The RBR endeavours to guide clinicians in providing evidence-informed primary care to Canadian children. The revisions are rigorously considered and are based on appraisal of a growing, albeit still limited, evidence base for pediatric preventive care.

P primary prevention, through primary care and public health interventions, plays a key role in preventing many of the leading causes of death and morbidity in childhood.¹⁻⁵ For example, each year, more children die in Canada from injuries than any single disease.¹ Motor vehicle-related deaths are the leading cause of injury in children, and numerous studies spanning several decades have demonstrated significantly reduced risk of death when children are properly restrained in car seats compared with children restrained by seat belts or unrestrained children.^{2,3} Primary prevention in early childhood might also reduce the risk of disease and morbidity in later adult life. A compelling case for the latter is supported by longitudinal studies that have demonstrated how cardiometabolic risk factors in childhood such as high body mass index (BMI), blood pressure, lipid level, and blood glucose level can track into adulthood, resulting in further health issues including

metabolic syndrome, type 2 diabetes, and atherosclerotic disease.^{6,7}

For the past 3 decades, primary care providers (PCPs) across Canada have used the Rourke Baby Record (RBR) to guide the provision of evidence-informed preventive care in children younger than 6 years of age.⁸⁻¹⁰ The RBR can be accessed at no cost online (www.rourkebabyrecord.ca) and is endorsed by the College of Family Physicians of Canada, the Canadian Paediatric Society, and Dietitians of Canada. The RBR knowledge translation tools for PCPs to support well-baby and well-child visits include RBR structured forms (Guides I to IV) in a printable version or embedded within electronic medical records, an immunization chart (Guide V), and a summary of supporting evidence and websites for the recommendations (Resources 1 to 4). There are supplemental resources for parents and caregivers on the RBR website. The RBR is also a teaching tool for undergraduate and postgraduate trainees across Canada, as exemplified by LearnFM, a matrix of educational resources developed by the Canadian Undergraduate Family Medicine Education Directors and supported by the College of Family Physicians of Canada.¹¹

This current clinical review aims to highlight the updates of the 2020 RBR. Our goal is to update busy PCPs with the current evidence and recommendations included in this newest version of the RBR.

Quality of evidence

Although the number of pediatric clinical trials and studies has increased in recent years, many challenges remain in developing evidence-based recommendations for pediatric preventive care in the primary care setting.¹² The number of topics reviewed by the US Preventive Services Task Force and the Canadian Task Force on Preventive Health Care (CTFPHC) for adults still outweigh those for children, and most pediatric recommendations are inconclusive, mainly because of the lack of high-quality evidence to support child-related preventive maneuvers.^{12,13} Faced with these limitations, the RBR team has continued to use multiple sources to incorporate the best available evidence and expert consensus into the updated recommendations, with a predilection for studies applicable to the Canadian context.

As with previous updates, the 2020 RBR is guided by the AGREE II (Appraisal of Guidelines for Research and Evaluation II; www.agreetrust.org) framework.¹⁴ In addition, we engaged in a new partnership with the McMaster Evidence Review and Synthesis Team (MERST) to help streamline our literature review methods. The MERST has previously supported the work of other official bodies that produce guidelines, such as the CTFPHC.¹⁵ To update existing or integrate new recommendations into the 2020 RBR, we reviewed the latest evidence in the areas of growth monitoring, nutrition, education and advice (including injury prevention,

behaviour and family issues, environmental health, and other issues), developmental surveillance, physical examination, investigations and screening, and immunization. We searched the literature from June 2016 (the last RBR literature update) to May 2019 using previously described methods.^{9,10} We developed new search strategies for issues pertinent to early childhood health and primary care that have emerged since the last version of the RBR in 2017 (eg, e-cigarettes). We used the GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology to critically evaluate primary research studies.¹⁶ Based on new evidence, policy statements, and reviews, we modified or added recommendations using our long-standing and user-friendly categorization system of good, fair, and consensus or inconclusive evidence, which are represented in **bold**, *italics*, and regular fonts in the RBR tools, respectively.

The core 2020 RBR team initially included an FP (L.R.), a pediatrician (D.L.), a pediatric clinical epidemiologist (P.L.), and research assistants (S.A. and E.T.) who were involved in the literature search, evidence appraisal, and final recommendations. The MERST assisted with organizing and screening the literature using DistillerSR (<https://www.evidencepartners.com/products/distillersr-systematic-review-software>). In 2019, the team expanded to include further expertise in the clinical practice of family medicine (I.B. and B.K.) and pediatrics (A.R.L.). All of the latter members took part in reviewing pertinent evidence associated with the final recommendations and the knowledge translation tools associated with the final 2020 RBR. A team member (J.R.) has been continuously involved since the original development of the RBR and currently has an oversight role that includes publication input, review, and approval. Our team of stakeholders and advisory members from the College of Family Physicians of Canada, the Canadian Paediatric Society, and Dietitians of Canada reviewed, approved, and endorsed the final 2020 RBR. Furthermore, we created and collaborated with a users' committee to ensure that the updated evidence was relevant, optimally incorporated, and accessible in the tools. The content of the 2020 RBR was finalized before the coronavirus disease 2019 (COVID-19) pandemic, and hence does not include literature or specific recommendations that might relate to COVID-19 and well-child care.

Main message

The main content revisions in the 2020 edition of the RBR are outlined below. **Table 1** provides the accompanying details and rationale for the changes.¹⁷⁻⁷⁶ The RBR website includes a version of the 2020 RBR with wording revisions in teal print for easy identification of the changes, as well as a list of the revisions (www.rourkebabyrecord.ca/updates).

Table 1. Revisions to the 2020 RBR: Modifications highlighted in bold.

| REVISION | DETAILS OR RATIONALE |
|--|--|
| <p>Growth monitoring</p> <ul style="list-style-type: none"> • WHO Growth Charts adapted for Canada with BMI tables and BMI calculator | <ul style="list-style-type: none"> • BMI tables and calculator are readily available from Dietitians of Canada website¹⁷ |
| <p>Nutrition</p> <ul style="list-style-type: none"> • Addition of Web link in Resources 1 to the 2019 Ontario Dietitians in Public Health Pediatric Nutrition Guidelines (birth to 6 y) • Breastfeeding might reduce gastrointestinal and respiratory tract infections • Lactating mothers are encouraged to consume a standard multivitamin or mineral supplement that contains vitamin D (400 IU/d) • <i>Iron fortified</i> term has been removed from the infant formula item • No bottles in bed recommendation has been added to the 12- and 15-month visits • Soy-based formula is not recommended for use in those with cow's milk protein allergy or in preterm infants, and might interfere with absorption of thyroxine replacement therapy in infants with congenital hypothyroidism • Introduction to solids: a few weeks before to just after 6 mo, guided by infant's readiness (CPS Caring for Kids; https://www.caringforkids.cps.ca/handouts/pregnancy-and-babies/feeding_your_baby_in_the_first_year), start iron-containing foods to avoid iron deficiency. A variety of soft-textured foods, ranging from purees to finger foods, can be introduced • "Allergenic foods" have been added to the 6- and 9-mo visits in bold font (indicating good strength of recommendation), as well as discussion at the 4-mo visit regarding future introduction. The statement in Resources 1 now includes more details: for all infants, including those at high risk of allergies, allergenic foods (especially eggs and peanut products) can be introduced with other solids around 6 mo, but not before 4 mo, as guided by the infant's signs of readiness. Once allergenic solids are introduced, they should be fed a few times a wk to maintain tolerance • Avoid all sweetened fruit drinks, sports drinks, energy drinks, and soft drinks; restrict fruit juice consumption to a maximum of half a cup (125 mL)/d. Limit the consumption of prepared food and beverage products that are high in sugar content • Limit and avoid consuming highly processed foods that are high in dietary sodium | <ul style="list-style-type: none"> • Contains current, detailed, and practical recommendations on nutrition for each age group, including general guidelines on fluid and foods, milestones, red flags, and safe handling of expressed breastmilk and formula preparation¹⁸ • The wording to describe the association between breastfeeding and infections is now less definitive to reflect the limitations of the evidence. Most studies were conducted in low- or middle-income countries and were of some type of observational design, where residual confounding and reverse causality might exist (eg, breastfeeding practices have been shown to differ between women of different sociodemographic backgrounds)¹⁹ • The 2017 RBR recommended that breastfeeding mothers should continue to take vitamin D supplements; the revision emphasizes that these mothers should continue to take a standard multivitamin that includes at least 400 IU/d of vitamin D^{20,21} • All infant formulas sold in Canada (except for a couple of very specialized items) contain enough iron to meet infant needs. Formulas generally contain iron concentrations between 0.4 mg/100 mL and 1.3 mg/100 mL¹⁸ • The recommendation for no bottles in bed, already present at 6-mo and 9-mo visits, has been added to visits up to 15 mo because of the importance of preventing dental caries and iron deficiency^{22,23} • Wording has been revised in line with current evidence of minimal concern for adverse effects on development or endocrine function in infants who consume soy-based infant formula. It is not recommended in preterm infants or in those with congenital hypothyroidism²⁴ • Babies are ready to try solids if they can hold their head up, sit with little help, open their mouth when food is offered, can accept food from a spoon and swallow it, and can turn their head to refuse food²⁵ • This is based on increasing supportive evidence from high-quality randomized controlled trials and systematic reviews²⁶⁻²⁹ • Wording has been revised to reflect current evidence that supports limiting the consumption of food and beverages high in sugar content³⁰ • New recommendation added based on a new CPS position statement. Dietary preferences, including those related to salty foods, start in childhood. High sodium intake in children might be associated with obesity and adult hypertension, as well as poor overall diet quality. The CPS recommends that physicians assess dietary sodium intake and counsel families and children using the reference tables and resources provided in the statement³¹ |

Table 1 continued on page 491

Table 1 continued from page 490

| REVISION | DETAILS OR RATIONALE |
|---|---|
| Education and advice | |
| Injury prevention | |
| <ul style="list-style-type: none"> The order of items in Resources 1 has been changed to transportation in motor vehicles, bicycles, safe sleeping environments, pacifier use, choking, drowning, burns, poisons and other toxins, falls, and firearm safety | <ul style="list-style-type: none"> This change in order in Resources 1 reflects a change in the prevalence of causes of accidental death in young children.³² The order of these items does not necessarily match that in the guides, which more closely follow the order of strength of recommendation |
| <ul style="list-style-type: none"> Never leave a child unattended in a vehicle | <ul style="list-style-type: none"> Since 2013, 1 child has died each year owing to hyperthermia in vehicles in Canada. Most were unintentional and were due to caregivers forgetting about the child in the car. Anticipatory guidance recommendations include reminding caregivers to never leave a child unattended in a vehicle, providing strategies for prevention of an event (creating habits such as always checking the back seat before locking the car door, and creating reminders by using smartphone apps, or by placing child-related objects in the front seat of the car), keeping the car door locked so children will not play inside without the caregiver's knowledge, etc.^{33,34} |
| <ul style="list-style-type: none"> Replace car seat if in a collision | <ul style="list-style-type: none"> Car seat wording has been updated and streamlined, and now includes the recommendation to replace the car seat if in a collision as this might limit its future effectiveness³⁵ |
| <ul style="list-style-type: none"> Children and youth younger than 16 y of age should not operate an ATV or a snowmobile, including youth models | <ul style="list-style-type: none"> This recommendation was added because the 2017 RBR provided a link to the CPS statement on prevention of ATV injuries in Resources 1 without an explicit recommendation. Children and youth operating ATVs and snowmobiles continue to suffer devastating morbidity and mortality³⁶ |
| <ul style="list-style-type: none"> Bicycles: wear a bicycle helmet and advocate for helmet legislation for all ages. Replace if it has sustained impact or is >5 y old | <ul style="list-style-type: none"> As per current evidence³⁷ |
| <ul style="list-style-type: none"> Healthy infants should be positioned on their backs on a firm surface for every sleep | <ul style="list-style-type: none"> Recommendations concerning safe sleeping environments were updated with information from the 2016 AAP Task Force on SIDS. An infant sleeping on a soft mattress might create a pocket or indentation on the surface, increasing the chance of rebreathing or suffocation in prone position^{38,39} |
| <ul style="list-style-type: none"> Counsel parents on the dangers of other contributory causes of SIDS such as bed sharing, overheating, maternal smoking, second-hand smoking, alcohol, or illicit or sedating drug use | <ul style="list-style-type: none"> Current evidence has been updated on the risk factors for SIDS, including bed sharing with someone whose ability to be alert or aroused is impaired because of sedating medications or substances^{38,39} |
| <ul style="list-style-type: none"> Infants should sleep in a crib, cradle, or bassinette that meets Health Canada regulations, is located in the parents' room for the first 6 mo of life, and is without soft objects, loose bedding, or similar items inside | <ul style="list-style-type: none"> The 2016 AAP Task Force on SIDS recommended that infants sleep close to the parents' bed on a separate surface, ideally until 12 mo of age but at least until 6 mo of age. They acknowledged the lack of specific evidence supporting the recommendation to stay in the parents' room until the first birthday, and that the first 6 mo were the most critical period where SIDS and sleep-related deaths were more likely to occur.^{38,39} In deciding the timing of moving an infant to his or her own room, assessment should include the risk factors for SIDS and implications of room sharing on parental sleep and breastfeeding |
| <ul style="list-style-type: none"> Swaddling is contraindicated once baby shows signs of attempting to roll | <ul style="list-style-type: none"> A definitive age to stop swaddling has been deleted as infants vary in the age they begin to roll over^{38,39} |
| <ul style="list-style-type: none"> Avoid hard, small and round, smooth, and sticky solid foods until 4 y of age | <ul style="list-style-type: none"> The age for food choking risk has been increased from 3 y to 4 y in line with current recommendations⁴⁰ |
| <ul style="list-style-type: none"> Recommend adult supervision, training for adults, 4-sided pool fencing with self-closing and self-latching gates, life jackets, swimming lessons, and boating safety to decrease the risk of drowning | <ul style="list-style-type: none"> Self-closing and self-latching pool enclosure gates further decrease the risk of drowning⁴¹ |
| <ul style="list-style-type: none"> For visits at 9 mo to 5 y, the item "burns" has replaced "keep hot water <49°C." Be vigilant with hot liquids on countertops | <ul style="list-style-type: none"> Once infants start walking, their risk of burns increases. A statement regarding hot liquids on countertops has been added because scalds were the most common mechanism of burn injuries presenting to the emergency department in Canada⁴² |
| <ul style="list-style-type: none"> For poisons and other toxins, keep medicines, cleaners, and other toxic substances locked up and out of children's reach. Have the local poison control centre number handy. Use of ipecac is contraindicated in children. Install carbon monoxide detectors | <ul style="list-style-type: none"> Wording has been broadened to include toxic substances in general. The recommendation on carbon monoxide detectors was moved to this section from the "Burns" section |

Table 1 continued on page 492

Table 1 continued from page 491

| REVISION | DETAILS OR RATIONALE |
|---|--|
| <p>Behaviour and family issues</p> <ul style="list-style-type: none"> • Inquire if there is difficulty making ends meet or if there is food insecurity • Literacy: encourage parents to read and sing to their infants and children and to limit television, video, and computer games to provide more opportunities for reading • Counsel on appropriate media use: for children < 2 y, screen time (eg, television, computer, and electronic games) is not recommended except for videocalling; for children 2 to 4 y, screen time should be limited to <1 h/d. Less is better, and educational and prosocial programming more acceptable | <ul style="list-style-type: none"> • There is increasing evidence that supports the importance of addressing social determinants of health to optimize early child development and long-term health outcomes. Validated questions include, “Within the past 12 months, did you worry that your food would run out before you got money to buy more, OR did the food not last and you didn’t have money to get more?”^{43,44} • There is preliminary evidence based mainly on small observational studies that early life exposure to music is correlated with changes in brain structure and function. Reading and singing should ideally begin with young infants^{45,46} • Because there is emerging evidence that young children might be able to learn words from and are able to engage in live videocalling with an adult and that videocalling facilitates social connection with family members elsewhere, the updated recommendation highlights the appropriate use of and opportunities offered by videocalling. The CPS and AAP guidelines on media use also emphasize the importance of parents as role models of healthy screen habits, and how parental media use might interfere with parent-child interactions and play^{47,48} |
| <p>Environmental health</p> <ul style="list-style-type: none"> • Second-hand smoke, e-cigarette, and cannabis exposure: there is no safe level of exposure. Advise caregivers to stop smoking and reduce second-hand smoke exposure, which contributes to childhood respiratory illnesses, SIDS, and neurobehavioural disorders. Offer smoking cessation resources. Educate parents on the health risks and harms associated with e-cigarettes and cannabis (including edibles), and on safe storage • Insect bites and repellents: prevent insect bites. Do not apply DEET to infants < 6 mo; to children 6 to 24 mo apply 10% DEET maximum once daily; to children 2 to 12 y apply 10% DEET maximum 3 times/d • Pesticides: ask about pesticide use and storage at home; avoid exposure. Wash all fruits and vegetables that cannot be peeled • Blood lead screening is recommended for children who in the past 6 mo lived in a house or apartment built before 1960 (revised from 1978) • Three additional risk factors to consider blood lead screening include children who have emigrated or been internationally adopted from a country where population lead levels are higher than in Canada, are at risk of lead exposure from water pipes, or require diagnostic investigations for neurodevelopmental delays and disorders | <ul style="list-style-type: none"> • Screening for exposure to e-cigarettes and cannabis and educating parents on the potential risks and harms might be important, given their widespread use. Also, with the legalization of cannabis, safe storage is important to prevent unintentional ingestion by children^{49,50} • Prevent insect bites by avoiding areas and times where insects and ticks are most active, taking precautions with physical barriers (eg, window screens and light-coloured clothes) and insect repellents⁵¹ • The 2017 RBR statement to use pesticide-free foods has been removed as it is not realistic for many and evidence of effectiveness is lacking. It has been replaced with recommendations for which there is evidence: asking about pesticide use and storage at home.⁵² An additional recommendation is to wash fruits and vegetables⁵³ • Lead was banned from interior house paints in Canada in 1960. Exterior paint in Canada might have contained some lead until 1990^{54,55} • The CPS published a practice point in 2019 highlighting the many potential sources of low-level lead exposure in children and the approach to management of lead toxicity⁵⁵ |

Table 1 continued on page 493

Table 1 continued from page 492

| REVISION | DETAILS OR RATIONALE |
|---|--|
| <p>Oral health</p> <ul style="list-style-type: none"> New item on management of teething discomfort: discomfort can be managed by providing gum massage with a cold facecloth or teething ring and appropriate use of oral analgesics (eg, acetaminophen [all ages] or ibuprofen if ≥ 6 mo). Anesthetics or numbing gels and teething necklaces are contraindicated Canadian Caries Risk Assessment Tool can be found at http://umanitoba.ca/CRA_Tool_ENG_Version.pdf | <ul style="list-style-type: none"> The 2017 RBR did not have a specific statement associated with the recommendation to screen for teething on the RBR guides from 6 to 15 mo. With the 2018 warning by the US Food and Drug Administration and Health Canada's recall of teething gels containing benzocaine because of the risk of methemoglobinemia and the lack of efficacy in teething, a new recommendation was added to guide clinicians on the management of teething.^{56,57} A Canadian study demonstrated that 50% of teething necklaces (made of amber) did not open with 15 lbs of force, which is a standard for safety of children's jewelry, nor did they open with 1.6 lbs of force, which is the amount required to occlude a child's airway.⁵⁸ Because of the risk of strangulation, choking, infection, and injury to the mouth, teething necklaces are contraindicated A new evidence-based Canadian Caries Risk Assessment Tool has been developed for non-dental health care providers, and is endorsed by the CPS (validation study pending) |
| <p>Developmental surveillance</p> <ul style="list-style-type: none"> The term <i>normal developmental milestones</i> has been improved to <i>typical developmental milestones</i> Note the following new red flag motor milestones: at 6 mo, no persistent closed or fisted hands and reaches or grasps objects with both hands equally; and at 9 and 12 mo, uses both hands equally Specific screening for ASD from 18 to 24 mo should be performed on all children with any of the following risk factors: failed items on the social-emotional-communication skills inquiry, sibling with autism, or developmental concern by parent, caregiver, or physician. Increased prevalence of ASD is also associated with prematurity, and certain chromosomal, genetic, and neurologic disorders. Standardized, evidence-based screening tools for detection of early ASD symptoms should be used as per guidelines | <ul style="list-style-type: none"> This modification was made to ensure inclusive and respectful use of terminology as it pertains to child development The most common physical disability in childhood is CP. Because a large proportion of children with CP might not have the perinatal risk factors (eg, prematurity, admission to the neonatal intensive care unit) that would streamline them to multidisciplinary follow-up programs, the primary care provider plays an important role in identifying children with CP or other neurodevelopmental problems. Literature review and international expert consensus identified 6 factors that should prompt referral for diagnostic assessment: hand preference before 12 mo, stiffness or tightness in legs between 6 and 12 mo, fisted hands after 4 mo, persistent head lag after 4 mo, inability to sit without support beyond 9 mo, and asymmetry of posture and movements after 4 mo. These have been incorporated into the developmental milestones and physical examination sections^{59,60} The CPS has published 3 new positions statements regarding the early detection, diagnostic assessment, and management of ASD.⁶¹⁻⁶³ Questionnaires and clinical screening tools for the detection of early ASD symptoms are presented in the first statement⁶¹ |

Table 1 continued on page 494

Table 1 continued from page 493

| REVISION | DETAILS OR RATIONALE |
|---|---|
| <p>Physical examination</p> <ul style="list-style-type: none"> • Blood pressure: check blood pressure at all visits for those at risk ≥3 y of age. Some risk factors include obesity, sleep-disordered breathing, prematurity, renal disease, congenital heart disease, diabetes, or taking medications that increase blood pressure • Corneal light reflex test has been deleted for infants younger than 6 mo of age • Intact palate (inspection, palpation) added to visits up to 1 mo of age • Check tongue mobility if there are breastfeeding problems • Teeth or caries risk assessment added to visits starting at 6 mo of age • Examination of the heart, lungs, and abdomen is included in all visits • Umbilicus: gently pat dry and review the signs and symptoms of infection • For hip examination, there is insufficient evidence to recommend routine diagnostic imaging for screening for developmental dysplasia of the hips, but examination of the hips should be included until at least 1 y, or until the child can walk. Examination includes assessing limb length discrepancy and asymmetric thigh or buttock (gluteal) creases, performing an Ortolani test (results usually negative after 3 mo), and testing for limited abduction (results usually positive after 3 mo). Consider selective imaging between 6 wk and 6 mo if there is a risk factor (eg, breech, family history, or hip instability on physical examination) • No head lag added to 6-mo visit, and muscle tone added to 9- and 12-mo visits • Spine (dimple or sinus) | <ul style="list-style-type: none"> • The fair grade recommendation to check blood pressure in children ≥3 y of age has not changed. Risk factors for hypertension are now clearly outlined in Resources 2, and Web links to the guidelines and definition for hypertension are made available⁶⁴ • Since strabismus can be common in the newborn period and intermittent strabismus can be normal in early infancy, examining for corneal light reflex is most clinically relevant at and after the 6-mo visit. Strabismus that does not resolve after 4 mo of age warrants referral⁶⁵ • Cleft lip or palate are common congenital anomalies and should be screened for during early well-baby visits. Visual inspection of the palate was added to detect a submucous cleft⁶⁶ • Tongue mobility becomes clinically relevant when there are breastfeeding problems. This can help avoid the overdiagnosis of clinically insignificant ankyloglossia⁶⁷ • See the new CPS-endorsed Canadian Caries Risk Assessment Tool (http://umanitoba.ca/CRA_Tool_ENG_Version.pdf) • This corrects a potential misperception that not including these items implied they were not indicated. The principle of the physical examination section, as stated in Guides I to IV, has always been that an appropriate age-specific physical examination is recommended at each visit. Evidence-based screening for specific conditions is highlighted • There is insufficient evidence to support the use of a topical antiseptic on umbilical cords compared to dry cord care to prevent infection in developed countries⁶⁸ • Additional details regarding the hip examination have been added to Resources 1. Because the Barlow and Ortolani tests can be simply performed together during the hip examination, they are listed in the physical examination section of Guides I and II. However, because the Barlow test is a test of laxity or instability and has less clinical significance than the Ortolani test, it is not emphasized in the explanation in Resources 1⁶⁹ • Abnormal tone or deep tendon reflexes, or asymmetric movements (moving one side more than other) might be early signs of CP or neuromotor disorder and suggest the need for further assessment^{59,60} • For visits up to 2 wk of age, examine the spine for cutaneous signs of occult spinal dysraphism⁷⁰ |
| <p>Investigations and screening</p> <ul style="list-style-type: none"> • “Hemoglobin (if at risk)” has been revised to “anemia screening (if at risk)” • Anemia screening: screening for iron deficiency anemia should be considered between 6 and 18 mo of age for infants and children from high-risk groups (eg, low socioeconomic status, Indigenous communities, newly arrived refugees, internationally adopted and immigrant children from resource-poor countries, low-birth-weight and premature infants, infants and children fed whole cow’s milk before 9 mo of age or at quantities >500 mL/d, prolonged bottle feeding beyond 15 mo of age, or suboptimal intake of iron-containing foods. Beyond this age, screen for anemia as per additional risk factors | <ul style="list-style-type: none"> • Because iron deficiency is a common cause of anemia, anemia screening, when indicated, should measure the hemoglobin and iron status (eg, ferritin and C-reactive protein levels)^{71,72} • The high-risk groups have been revised based on most recent evidence. Some of these groups (eg, Indigenous communities, newly arrived children) might be at risk of anemia because of poverty, food insecurity, and other factors^{71,72} |

Table 1 continued on page 495

Table 1 continued from page 494

| REVISION | DETAILS OR RATIONALE |
|--|--|
| Immunizations | |
| <ul style="list-style-type: none"> During vaccination, pain reduction strategies with good evidence include breastfeeding or use of sweet-tasting solutions, giving the most painful vaccine last, and consideration of topical anesthetics For the DTaP vaccine, immunization should be offered to all pregnant women (ie, ≥ 13 wk of gestation, ideally between 27 and 32 wk) to provide immediate protection to infants <6 mo of age For children in medically high-risk groups (eg, immunocompromising conditions, chronic renal failure, or dialysis), see the hepatitis B chapter in the Canadian Immunization Guide for schedules regarding timing and number of hepatitis B vaccine doses and monitoring of antibody levels Influenza vaccine recommended for all children, particularly those aged 6 to 59 mo and other children at high risk Children aged 2 to 18 y should be given quadrivalent inactivated influenza vaccine or live attenuated influenza vaccine if not contraindicated. If a quadrivalent vaccine is not available, trivalent inactivated vaccine should be used. Live attenuated influenza vaccine is contraindicated in children with immune-compromising conditions, with severe asthma (defined as current active wheezing or currently on oral or high-dose inhaled glucocorticosteroids, or medically attended wheezing within the past 7 d), or taking acetylsalicylic acid | <ul style="list-style-type: none"> Based on evidence-based clinical practice guidelines for vaccination pain reduction strategies⁷³ As per current evidence and NACI recommendations⁷⁴ As per current evidence and recommendations from NACI⁷⁵ As per current evidence⁷⁶ |
| <p>AAP—American Academy of Pediatrics, ASD—autism spectrum disorder, ATV—all-terrain vehicle, BMI—body mass index, CP—cerebral palsy, CPS—Canadian Paediatric Society, DEET—diethyltoluamide, DTaP—diphtheria and tetanus toxoids and acellular pertussis, NACI—National Advisory Committee on Immunization, RBR—Rourke Baby Record, SIDS—sudden infant death syndrome, WHO—World Health Organization.</p> | |

General principles

- If a baby did not have a visit in the first month of life, it might be important to perform items that are typically part of the early visits, such as femoral pulse, palate, and spine and back examinations, whenever the initial assessment ultimately occurs, since these items are not performed again in later visits. This is particularly relevant if the infant was previously seen by another health care professional, or assessed via virtual care during the COVID-19 pandemic.
- Some items on the RBR are repeated at several visits. The PCP might elect to readdress items previously discussed where they perceive a risk or need.
- The order of items in some sections has been revised. In the “Nutrition” and in the “Education and Advice” sections, we have attempted to list items in order of strength of recommendation: items with good evidence appear first, followed by items with fair evidence, and items with inconclusive evidence or consensus appear last. Where possible, physical examination items have been organized from head to toe, taking into consideration the strength of recommendation.
- Web links have been revised as per current evidence. They are identified on Resources 1 through 4 with the title or topic followed by the reference organization or journal. There are links on the RBR website for easy accessibility.

- A new landscape paper format has a larger font size and more writing space, enabling a double-sided, 3-visits-per-page format. This is similar to the pre-existing “stretched” version that stretches each guide vertically. The original 3 visits per page format is now available as a fillable PDF.

Growth monitoring. Since calculation of BMI is recommended for children older than 2 years of age, there is now a link to Dietitians of Canada BMI tables and calculator resources.¹⁷ Body mass index curves are available through the link for growth chart sets.

Nutrition. Several practical online resources for nutrition in children younger than 6 years of age have been added to Resources 1, including guidelines from the Ontario Dietitians in Public Health¹⁸ and the Baby-Friendly Initiative Strategy for Ontario,⁷⁷ and statements from the Canadian Paediatric Society on timing of allergenic food introduction²⁶ and dietary sodium.³¹ Content changes related to nutrition include the following: some qualification of the association between breastfeeding and gastrointestinal and respiratory infections to reflect the limitations of the evidence¹⁹; wording to emphasize that lactating mothers should continue a standard multivitamin supplement with at least 400 IU per day of vitamin D^{20,21}; removal of the words “iron fortified”

to describe recommended infant formulas¹⁸; repeated advice at 12- and 15-month visits against bottles in bed^{22,23}; advice against using soy-based infant formula in preterm infants and in those with cow's milk protein allergy, and to use caution in infants being monitored for congenital hypothyroidism²⁴; advice that introduction of solids should be guided by infant readiness, and should start between 4 and 6 months of age²⁵; addition of good strength of recommendation evidence (bold font) for introducing allergenic foods (especially eggs and peanut products) in infants at high risk of allergies, and for maintaining tolerance by continuing those foods several times a week²⁶⁻²⁹; and advice to limit the consumption of foods (in addition to beverages) high in sugar³⁰ and to limit consumption of highly processed foods high in dietary sodium.³¹

Education and advice

Injury prevention: The list of preventable injuries in Resources 1 has been placed in order from most to least prevalent cause of accidental death in young children.³² Updates include the following advice: never leave a child unattended in a vehicle^{33,34}; replace any car seat involved in a collision³⁵ and any bicycle helmet if it has sustained an impact or is more than 5 years old³⁷; children and youth younger than 16 years of age should not operate an all-terrain vehicle or a snowmobile, including youth models³⁶; healthy infants should be positioned on their backs on a firm surface for every sleep; avoid use of alcohol or illicit or sedating drugs, as they are risk factors for sudden infant death syndrome; do not swaddle infants once they show signs of attempting to roll^{38,39}; do not introduce solid and sticky foods until 4 years of age because of choking risk (revised from 3 years of age)⁴⁰; pool fencing should include self-closing and self-latching gates⁴¹; and be vigilant with hot liquids on countertops because of the risk of burns.⁴²

Behaviour and family issues: Revised items include validated poverty identification questions about food security,^{43,44} and advice that both reading and singing should begin with young infants^{45,46}; screen time should be optimally managed by children, parents, and caregivers; and videocalling can improve communication with family and friends.^{47,48}

Environmental health items: Updated items include revised wording to educate parents on the health risks and harms associated with e-cigarettes and cannabis (including edibles) and on their safe storage^{49,50}; advice on how to prevent insect bites⁵¹; omission of recommendation for using pesticide-free foods; recommendation to ask about pesticide use and storage at home⁵²; suggestion to wash all fruits and vegetables that cannot be peeled⁵³; and a list of changed and expanded risk factors for blood lead screening.^{54,55}

Oral health: Management of teething discomfort has been added⁵⁶⁻⁵⁸ in addition to the Smiles for Life

curriculum for non-dental health professionals (<https://www.smilesforlifeoralhealth.org>). There is a new Canadian Paediatric Society-endorsed Canadian Caries Risk Assessment Tool (http://umanitoba.ca/CRA_Tool_ENG_Version.pdf).

Developmental surveillance. Revisions regarding specific developmental milestones have been made, including changing the term *normal developmental milestones* to *typical developmental milestones*, and expanding motor milestones for early detection of cerebral palsy.^{59,60} The evidence and full list of associated publications supporting this recommendation on cerebral palsy is available at <https://www.childhooddisability.ca/early-detection-of-cp/>.

Additional risk factors have been added for autism spectrum disorder, as well as new standardized evidence-based screening tools for autism spectrum disorder detection, assessment, and management.⁶¹⁻⁶³

Physical examination. Examination of the heart, lungs, and abdomen is now included in all visits. This corrects a misperception that not including these items implied they were not indicated. The principle of the physical examination section, as stated on this heading in Guides I to IV, has always been that an appropriate age-specific physical examination is recommended at each visit. Evidence-based screening for specific conditions is highlighted.

Other revised maneuvers include listing risk factors for elevated blood pressure in children older than 3 years of age⁶⁴; deleting corneal light reflex from the examination of infants younger than 6 months of age⁶⁵; examining for intact palate⁶⁶; examining for tongue mobility only if there are breastfeeding problems⁶⁷; outlining umbilical cord care⁶⁸; detailing hip assessment and consideration of selective imaging⁶⁹; expanding muscle tone and motor maneuvers^{59,60}; and examining the back and spine at 1- and 2-week visits.⁷⁰

Investigations and screening. Anemia screening has been revised to reflect the high-risk groups for iron deficiency anemia based on current evidence.^{71,72}

Immunizations. Guide V and Resources 3 have been updated with the latest recommendations from the National Advisory Committee on Immunization. Changes in this edition of the RBR include the recommendation to give the most painful vaccine last as an additional pain reduction strategy,⁷³ and revisions to recommendations for diphtheria and tetanus toxoids and acellular pertussis,⁷⁴ hepatitis B,⁷⁵ and influenza vaccines.⁷⁶

Conclusion

The 2020 edition of the RBR continues its tradition of updating its recommendations for the preventive care of infants and young children based on new evidence. We have increased the rigour of our process of evidence

review and appraisal with new partnerships for this 2020 edition. In outlining the rationale and evidence underlying the updates and changes in the RBR recommendations in this article, we hope to help educate clinicians who provide primary care to children on best practices.

In the future, the RBR group is planning an end-user (clinicians and parents) satisfaction evaluation with the RBR guides and resources. This feedback would direct further development to optimize the usability, accessibility, and effectiveness of the tools.

Finally, primary care has dramatically changed since the COVID-19 pandemic onset, with increased reliance on virtual, as opposed to in-person, visits. We will seek ways to support PCPs with the implementation of the RBR within the challenging and shifting landscape of current health care delivery to ensure that infants and children continue to receive high-quality primary care. 🌿

Dr Li is Clinician-Scientist in the Centre for Outcomes Research and Evaluation at the McGill University Health Centre Research Institute in Montreal, Que, Associate Professor in the Department of Pediatrics at McGill University, and a general pediatrician at the Montreal Children's Hospital. **Dr Rowan-Legg** is a pediatrician in the Division of Pediatric Medicine and Associate Professor in the Department of Pediatrics at the University of Ottawa in Ontario, and a pediatrician at the Children's Hospital of Eastern Ontario in Ottawa. **Dr Kwok** is a lecturer in the Department of Family and Community Medicine at the University of Toronto in Ontario and a family physician at Unity Health Toronto (St Michael's Hospital) in Toronto. **Dr Bayoumi** is Assistant Professor in the Department of Family Medicine and is cross-appointed to the Department of Public Health Sciences at Queen's University in Kingston, Ont, and is a fellow at ICES. **Ms Arulthas** is a former research assistant in the Centre for Outcomes Research and Evaluation at the McGill University Health Centre Research Institute. **Ms Tedone** is a PhD candidate at McGill University. **Dr Leduc** is Associate Professor of Pediatrics in the Faculty of Medicine at the McGill University Health Centre. **Dr J. Rourke** is Professor Emeritus in the Faculty of Medicine at Memorial University of Newfoundland in St John's. **Dr L. Rourke** is Professor Emerita in the Faculty of Medicine at Memorial University of Newfoundland.

Contributors

All authors contributed to the literature review and interpretation, and to the development of the 2020 Rourke Baby Record. **Drs Li, L. Rourke, and Rowan-Legg** drafted the article. All authors contributed to editing and reviewing the drafts, and approved the final submission.

Competing interests

The Government of Ontario provides annual funding to support the updating and development of the Rourke Baby Record (RBR); funding is administered through McMaster University. For the fiscal year ending March 31, 2020, a total of \$63 000 was provided; of this, approximately \$19 000 was used for honoraria, which was divided among some of the authors of this manuscript. The licensing fee for electronic medical record use of the RBR (for electronic medical record firms not licensed in Ontario) goes to the Memorial University of Newfoundland Rourke Baby Record Development Fund. No royalties are received for the RBR, and there are no honoraria from commercial interests. In-kind support comes from Memorial University of Newfoundland and the 3 endorsing organizations: the Canadian Paediatric Society, the College of Family Physicians of Canada, and Dietitians of Canada. **Dr Li** is funded by a Canadian Institutes of Health Research New Investigator Salary Award.

Correspondence

Dr Patricia Li; e-mail patricia.li@mcgill.ca

References

- Yanchar NL, Warda LJ, Fuselli P. Child and youth injury prevention: a public health approach. *Paediatr Child Health* 2012;17(9):511-2.
- Williams SB, Whitlock EP, Edgerton EA, Smith PR, Beil TL; US Preventive Services Task Force. Counseling about proper use of motor vehicle occupant restraints and avoidance of alcohol use while driving: a systematic evidence review for the U.S. Preventive Services Task Force. *Ann Intern Med* 2007;147(3):194-206.
- Durbin DR, Hoffman BD; Council on Injury, Violence, and Poison Prevention. Child passenger safety. *Pediatrics* 2018;142(5):e20182460. Epub 2018 Aug 30.
- Plachta-Danielzik S, Kehden B, Landsberg B, Schaffrath Rosario A, Kurth BM, Arnold C, et al. Attributable risks for childhood overweight: evidence for limited effectiveness of prevention. *Pediatrics* 2012;130(4):e865-71. Epub 2012 Sep 3.
- Kuhle S, Allen AC, Veugelers PJ. Prevention potential of risk factors for childhood overweight. *Can J Public Health* 2010;101(5):365-8.
- Llewellyn A, Simmonds M, Owen CG, Woolacott N. Childhood obesity as a predictor of morbidity in adulthood: a systematic review and meta-analysis. *Obes Rev* 2016;17(1):56-67. Epub 2015 Oct 6.
- Simmonds M, Llewellyn A, Owen CG, Woolacott N. Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. *Obes Rev* 2016;17(2):95-107. Epub 2015 Dec 23.
- Rourke JT, Rourke LL. Well baby visits: screening and health promotion. *Can Fam Physician* 1985;31:997-1002.
- Li P, Rourke L, Leduc D, Arulthas S, Rezk K, Rourke J. Rourke Baby Record 2017. Clinical update for preventive care of children up to 5 years of age. *Can Fam Physician* 2019;65:183-91 (Eng), e99-109 (Fr).
- Riverin B, Li P, Rourke L, Leduc D, Rourke J. Rourke Baby Record 2014. Evidence-based tool for the health of infants and children from birth to age 5. *Can Fam Physician* 2015;61:949-55 (Eng), e491-8 (Fr).
- Keegan DA, Scott I, Sylvester M, Tan A, Horrey K, Weston WW. Shared Canadian Curriculum in Family Medicine (SHARC-FM). Creating a national consensus on relevant and practical training for medical students. *Can Fam Physician* 2017;63:e223-31. Available from: <https://www.cfp.ca/content/cfp/63/4/e223.full.pdf>. Accessed 2021 Jun 14.
- Melnik BM, Grossman DC, Chou R, Mabry-Hernandez I, Nicholson W, DeWitt TG, et al. USPSTF perspective on evidence-based preventive recommendations for children. *Pediatrics* 2012;130(2):e399-407. Epub 2012 Jul 2.
- Canadian Task Force on Preventive Health Care. *Published guidelines*. Calgary, AB: Canadian Task Force on Preventive Health Care; 2019. Available from: <https://canadiantaskforce.ca/guidelines/published-guidelines/>. Accessed 2020 Jul 29.
- Brouwers MC, Kerkvliet K, Spithoff K; AGREE Next Steps Consortium. The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. *BMJ* 2016;352:i1152. Erratum in: *BMJ* 2016;354:i4852.
- Warren R, Kenny M, Bennett T, Fitzpatrick-Lewis D, Ali MU, Sherifali D, et al. Screening for developmental delay among children aged 1-4 years: a systematic review. *CMAJ Open* 2016;4(1):E20-7.
- Guyatt G, Oxman AD, Akl EA, Kunz R, Vist G, Brozek J, et al. GRADE guidelines: 1. Introduction—GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol* 2011;64(4):383-94. Epub 2010 Dec 31.
- Dietitians of Canada. *WHO growth charts for Canada*. Toronto, ON: Dietitians of Canada; 2019. Available from: <https://www.dietitians.ca/Secondary-Pages/Public/Who-Growth-Charts.aspx>. Accessed 2020 Jun 23.
- Aqui C, Atkinson L, Cardinal M, Loewenberger E, Morgan R. *Pediatric nutrition guidelines (birth to six years) for health professionals*. Ontario Dietitians in Public Health; 2019. Available from: <https://www.odph.ca/upload/membership/document/2019-06/york-9367224-v2-2019-finalized-odph-pediatric-nutrition-guidelines.pdf>. Accessed 2020 Jun 23.
- Horta BL, Victora CG. *Short term effects of breastfeeding: a systematic review on the benefits of breastfeeding on diarrhoea and pneumonia mortality*. Geneva, Switzerland: World Health Organization; 2013. Available from: https://apps.who.int/iris/bitstream/handle/10665/95585/9789241506120_eng.pdf;jsessionid=48A19BDB8BE508E378778B2C9979A81A?sequence=1. Accessed 2020 Jun 23.
- Health Canada. *Vitamin D and calcium: updated dietary reference intakes*. Ottawa, ON: Government of Canada; 2020. Available from: <https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating/vitamins-minerals/vitamin-calcium-updated-dietary-reference-intakes-nutrition.html>. Accessed 2020 Jun 23.
- Godel JC; Canadian Paediatric Society, First Nations, Inuit and Métis Health Committee. Vitamin D supplementation: recommendations for Canadian mothers and infants. *Paediatr Child Health* 2007;12(7):583-9.
- Health Canada, Canadian Paediatric Society, Dietitians of Canada, Breastfeeding Committee for Canada. *Nutrition for healthy term infants: recommendations from six to 24 months. A joint statement of Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada*. Ottawa, ON: Government of Canada; 2014. Available from: <https://www.canada.ca/en/health-canada/services/canada-food-guide/resources/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months-6-24-months.html#>. Accessed 2020 May 25.
- Parkin PC, Maguire JL. Iron deficiency in early childhood. *CMAJ* 2013;185(14):1237-8.
- Bhatia J, Greer F; American Academy of Pediatrics Committee on Nutrition. Use of soy protein-based formulas in infant feeding. *Pediatrics* 2008;121(5):1062-8.
- Caring for Kids. *Feeding your baby in the first year*. Ottawa, ON: Canadian Paediatric Society; 2020. Available from: https://www.caringforkids.cps.ca/handouts/feeding_your_baby_in_the_first_year. Accessed 2020 Jun 23.
- Abrams EM, Hildebrand K, Blair B, Chan ES. Timing of introduction of allergenic solids for infants at high risk. *Paediatr Child Health* 2019;24(1):56-7. Epub 2019 Feb 15.
- Ierodiakonou D, Garcia-Larsen V, Logan A, Groome A, Cunha S, Chivinge J, et al. Timing of allergenic food introduction to the infant diet and risk of allergic or autoimmune disease: a systematic review and meta-analysis. *JAMA* 2016;316(11):1181-92.
- Natsume O, Kabashima S, Nakazato J, Yamamoto-Hanada K, Narita M, Kondo M, et al. Two-step egg introduction for prevention of egg allergy in high-risk infants with eczema (PETIT): a randomised, double-blind, placebo-controlled trial. *Lancet* 2017;389(10066):276-86. Epub 2016 Dec 9.
- Du Toit G, Roberts G, Sayre PH, Plaut M, Bahnson HT, Mitchell H, et al. Identifying infants at high risk of peanut allergy: the Learning Early About Peanut Allergy (LEAP) screening study. *J Allergy Clin Immunol* 2013;131(1):135-43.E12. Epub 2012 Nov 19.
- Pound CM, Critch JN, Thiessen P, Blair B; Canadian Paediatric Society Nutrition and Gastroenterology Committee. *A proposal to increase taxes on sugar-sweetened beverages in Canada*. Ottawa, ON: Canadian Paediatric Society; 2020. Available from: <https://www.cps.ca/en/documents/position/tax-on-sugar-sweetened-beverages>. Accessed 2020 Jun 23.
- Gowrishankar M, Blair B, Rieder MJ. Dietary intake of sodium by children: why it matters. *Paediatr Child Health* 2020;25(1):47-61. Epub 2020 Feb 6.

32. Yao X, Skinner R, McFaul S, Thompson W. At-a-glance—2015 injury deaths in Canada. *Health Promot Chronic Dis Prev Can* 2019;39(6-7):225-31.
33. Ho K, Minhas R, Young E, Sgro M, Huber JF. Paediatric hyperthermia-related deaths while entrapped and unattended inside vehicles: the Canadian experience and anticipatory guidance for prevention. *Paediatr Child Health* 2020;25(3):143-8. Epub 2019 Jul 16.
34. Healthychildren.org. *Prevent child deaths in hot cars*. Itasca, IL: American Academy of Pediatrics; 2019. Available from: <https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Prevent-Child-Deaths-in-Hot-Cars.aspx>. Accessed 2020 Jun 23.
35. Transport Canada. *Choosing a child car seat or booster seat*. Ottawa, ON: Government of Canada; 2019. Available from: <https://tc.canada.ca/en/road-transportation/child-car-seat-safety/choosing-child-car-seat-booster-seat>. Accessed 2021 May 25.
36. Yanchar NL. Preventing injuries from all-terrain vehicles. *Paediatr Child Health* 2012;17(9):513-4.
37. United States Consumer Product Safety Commission. *Which helmet for which activity?* Bethesda, MD: United States Consumer Product Safety Commission; 2014. Available from: <https://www.cpsc.gov/safety-education/safety-guides/sports-fitness-and-recreation-bicycles/which-helmet-which-activity>. Accessed 2020 Jun 23.
38. Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: updated 2016 recommendations for a safe infant sleeping environment. *Pediatrics* 2016;138(5):e20162938.
39. Moon RY; Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: evidence base for 2016 updated recommendations for a safe infant sleeping environment. *Pediatrics* 2016;138(5):e20162940.
40. Cyr C; Canadian Paediatric Society Injury Prevention Committee. Preventing choking and suffocation in children. *Paediatr Child Health* 2012;17(2):91-4.
41. Denny SA, Quan L, Gilchrist J, McCallin T, Shenoi R, Yusuf S, et al. Prevention of drowning. *Pediatrics* 2019;143(5):e20190850. Epub 2019 Mar 15.
42. Crain J, McFaul S, Rao DP, Do MT, Thompson W. At-a-glance. Emergency department surveillance of thermal burns and scalds, electronic Canadian Hospitals Injury Reporting and Prevention Program, 2013. *Health Promot Chronic Dis Prev Can* 2017;37(1):30-1.
43. Hager ER, Quigg AM, Black MM, Coleman SM, Heeren T, Rose-Jacobs R, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics* 2010;126(1):e26-32.
44. Fazalulasha F, Taras J, Morinis J, Levin L, Karmali K, Neilson B, et al. From office tools to community supports: the need for infrastructure to address the social determinants of health in paediatric practice. *Paediatr Child Health* 2014;19(4):195-9.
45. Shaw A; Canadian Paediatric Society Community Pediatrics Committee. Read, speak, sing: promoting early literacy in the health care setting. *Paediatr Child Health* 2021;26(3):182-8.
46. Fernandez S. Music and brain development. *Pediatr Ann* 2018;47(8):e306-8.
47. Canadian Paediatric Society; Digital Health Task Force. Screen time and young children: promoting health and development in a digital world. *Paediatr Child Health* 2017;22(8):461-77. Epub 2017 Oct 9. Erratum in: *Paediatr Child Health* 2018;23(1):83.
48. American Academy of Pediatrics Council on Communications and Media. Media and young minds. *Pediatrics* 2016;138(5):e20162591.
49. Grant CN, Bélanger RE. Cannabis and Canada's children and youth. *Paediatr Child Health* 2017;22(2):98-102. Epub 2017 May 3.
50. Stanwick R. E-cigarettes: are we renormalizing public smoking? Reversing five decades of tobacco control and revitalizing nicotine dependency in children and youth in Canada. *Paediatr Child Health* 2015;20(2):101-5.
51. Onyett H; Canadian Paediatric Society Infectious Diseases and Immunization Committee. Preventing mosquito and tick bites: a Canadian update. *Paediatr Child Health* 2014;19(6):326-32.
52. Roberts JR, Karr CJ; Council on Environmental Health. Pesticide exposure in children. *Pediatrics* 2012;130(6):e1765-88. Epub 2012 Nov 26. Erratum in: *Pediatrics* 2013;131(5):1013-4.
53. Trasande L, Shaffer RM, Sathyanarayana S; American Academy of Pediatrics Council on Environmental Health. Food additives and child health. *Pediatrics* 2018;142(2):e20181410.
54. Government of Canada. *Reduce your exposure to lead*. Ottawa, ON: Government of Canada; 2016. Available from: <https://www.canada.ca/en/health-canada/services/home-garden-safety/reduce-your-exposure-lead.html>. Accessed 2020 Jun 23.
55. Buka I, Hervouet-Zeiber C. Lead toxicity with a new focus: addressing low-level lead exposure in Canadian children. *Paediatr Child Health* 2019;24(4):293-4. Epub 2019 Jun 21.
56. Health Canada. *Oragel recall (2018-05-29)*. Ottawa, ON: Government of Canada; 2018. Available from: <https://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2018/67490-eng.php>. Accessed 2020 Jun 23.
57. US Food and Drug Administration. *Risk of serious and potentially fatal blood disorder prompts FDA action on oral over-the-counter benzocaine products used for teething and mouth pain and prescription local anesthetics*. Silver Spring, MD: US Food and Drug Administration; 2018. Available from: <https://www.fda.gov/drugs/drug-safety-and-availability/risk-serious-and-potentially-fatal-blood-disorder-prompts-fda-action-oral-over-the-counter-benzocaine>. Accessed 2020 Jun 23.
58. Soudek L, McLaughlin R. Fad over fatality? The hazards of amber teething necklaces. *Paediatr Child Health* 2018;23(2):106-10. Epub 2017 Nov 28.
59. Boychuck Z, Andersen J, Bussièrès A, Fehlings D, Kirton A, Li P, et al. International expert recommendations of clinical features to prompt referral for diagnostic assessment of cerebral palsy. *Dev Med Child Neurol* 2020;62(1):89-96. Epub 2019 Apr 25.
60. Childhood Disability LINK. *Early detection of cerebral palsy*. Montreal, QC: Childhood Disability LINK; 2020. Available from: <https://www.childhooddisability.ca/early-detection-of-cp/>. Accessed 2020 Jun 23.
61. Zwaigenbaum L, Brian JA, Ip A. Early detection for autism spectrum disorder in young children. *Paediatr Child Health* 2019;24(7):424-43. Epub 2019 Oct 24.
62. Brian JA, Zwaigenbaum L, Ip A. Standards of diagnostic assessment for autism spectrum disorder. *Paediatr Child Health* 2019;24(7):444-60. Epub 2019 Oct 24.
63. Ip A, Zwaigenbaum L, Brian JA. Post-diagnostic management and follow-up care for autism spectrum disorder. *Paediatr Child Health* 2019;24(7):461-77. Epub 2019 Oct 24.
64. Flynn JT, Kaelber DC, Baker-Smith CM, Blowey D, Carroll AE, Daniels SR, et al. Clinical practice guideline for screening and management of high blood pressure in children and adolescents. *Pediatrics* 2017;140(3):e20171904. Epub 2017 Aug 21. Errata in: *Pediatrics* 2017;140(6):e20173035, *Pediatrics* 2018;142(3):e20181739.
65. Donahue SP, Baker CN; American Academy of Pediatrics Committee on Practice and Ambulatory Medicine, American Academy of Pediatrics Section on Ophthalmology, American Association of Certified Orthoptists, American Association for Pediatric Ophthalmology and Strabismus. Procedures for the evaluation of the visual system by pediatricians. *Pediatrics* 2016;137(1):e20153597. Epub 2015 Dec 7.
66. Lewis CW, Jacob LS, Lehmann CU; American Academy of Pediatrics Section on Oral Health. The primary care pediatrician and the care of children with cleft lip and/or cleft palate. *Pediatrics* 2017;139(5):e20170628. Erratum in: *Pediatrics* 2017;140(3):e20171921.
67. Rowan-Legg A. Ankyloglossia and breastfeeding. *Paediatr Child Health* 2015;20(4):209-18.
68. Imdad A, Bautista RM, Senen KA, Uy ME, Mantaring JB 3rd, Bhutta ZA. Umbilical cord antiseptics for preventing sepsis and death among newborns. *Cochrane Database Syst Rev* 2013;(5):CD008635.
69. Shaw BA, Segal LS; American Academy of Pediatrics Section on Orthopaedics. Evaluation and referral for developmental dysplasia of the hip in infants. *Pediatrics* 2016;138(6):e20163107. Epub 2016 Nov 21.
70. Dias M, Partington M; American Academy of Pediatrics Section on Neurologic Surgery. Congenital brain and spinal cord malformations and their associated cutaneous markers. *Pediatrics* 2015;136(4):e1105-19.
71. Unger SL, Fenton TR, Jetty R, Critch JN, O'Connor DL. Iron requirements in the first 2 years of life. *Paediatr Child Health* 2019;24(8):555-6. Epub 2019 Dec 9.
72. Baker RD, Greer FR; American Academy of Pediatrics Committee on Nutrition. Diagnosis and prevention of iron deficiency and iron-deficiency anemia in infants and young children (0-3 years of age). *Pediatrics* 2010;126(5):1040-50. Epub 2010 Oct 5.
73. Taddio A, McMurtry CM, Shah V, Riddell RP, Chambers CT, Noel M, et al. Reducing pain during vaccine injections: clinical practice guideline. *CMAJ* 2015;187(13):975-82. Epub 2015 Aug 24.
74. Brophy J, Bačić O, Tunis MC. Summary of the NACI update on immunization in pregnancy with tetanus toxoid, reduced diphtheria toxoid and reduced acellular pertussis (Tdap) vaccine. *Can Commun Dis Rep* 2018;44(3-4):91-4.
75. Health Canada. *Hepatitis B vaccine: Canadian immunization guide*. Ottawa, ON: Government of Canada; 2020. Available from: <https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-7-hepatitis-b-vaccine.html>. Accessed 2020 Jun 23.
76. Health Canada. *Canadian immunization guide chapter on influenza and statement on seasonal influenza vaccine for 2019-2020*. Ottawa, ON: Government of Canada; 2019. Available from: <https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/canadian-immunization-guide-statement-seasonal-influenza-vaccine-2019-2020.html>. Accessed 2020 Jun 23.
77. Baby-Friendly Initiative Ontario. *Infant formula: what you need to know*. Toronto, ON: Best Start Resource Centre; 2020. Available from: <https://resources.beststart.org/product/b19e-infant-formula-booklet/>. Accessed 2020 Jun 23.

This article is eligible for Mainpro+ certified Self-Learning credits. To earn credits, go to www.cfp.ca and click on the Mainpro+ link. This article has been peer reviewed. *Can Fam Physician* 2021;67:488-98. DOI: 10.46747/cfp.6707488 La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro de juillet 2021 à la page e157.