

# EMSC/CHILD READY CONNECTION NEWSLETTER

NOVEMBER 2015: VOLUME 3, ISSUE 11

A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation*) is provided to children and adolescents, no matter where they live, attend school or travel.

**THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME WITH THE RIGHT RESOURCES!**



**Child Ready Montana-** State Partnership of Regionalized Care (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

**Exciting news and events are going on this month!**

TAKE THE BORN IN MT FACT QUIZ- SEE PAGE 2

LOST COST PEDIATRIC TRAUMA-ARE YOU READY? A LIVE SYMPOSIUM ON DECEMBER 16TH- SEE PAGE 4 FOR REGISTRATION INFORMATION.

SEE THE REVISED/APPROVED ACEP PRINCIPLES OF APPROPRIATE PATIENT TRANSFER— PAGE 7.

CHILDREN AND HAND SANITIZERS-**DANGER**- SEE PAGE 8

RESOURCES FOR KIDS-GOING TO THE HOSPITAL/ED.—SEE PAGE 8

ANSWER THE TRIVIA AND WIN A FREE REGISTRATION TO THE LIVE SYMPOSIUM—SEE PAGE 9



EMS & Trauma Section  
EMS for Children,  
PO Box 202951,  
1400 Broadway,  
Room C314A,  
Helena MT 59620

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## PREMATURITY IN MONTANA

In 2013, Montana's preterm birth rate declined, giving more babies a healthy start — and earning the state a “B” grade on the 2013 March of Dimes Report Card. Montana's preterm birth rate was 10.5 percent in 2013, down from 11.9 percent in 2006, the year the national rate peaked. **A premature, or preterm birth, is one that happens before 37 weeks.** At least 39 weeks of pregnancy are important to a baby's health because many important organs, including the brain and lungs, are not completely developed until then.

Montana is part of a national trend toward improved rates. The March of Dimes estimates that since 2006, some 231,000 fewer babies have been born premature because of the sustained interventions put in place by states, saving \$11.9 billion in health care and other costs.

The national preterm birth rate fell to 11.4 percent in 2013 — the lowest in 17 years — meeting the federal Healthy People 2020 goal seven years early. The initiative, launched in 2010, set a 10-year agenda for improving the nation's health. Despite this progress, the nation still received a “C” on the annual report card and still has the highest rate of preterm birth of any industrialized country.

**Montana's improvement on the report card is a testament to the hard work of Montana's state and local health departments, the hospitals and health care providers.**

Pre-term birth is the leading cause of newborn death, and babies who survive an early birth often face the risk of lifetime health challenges, such as breathing problems, cerebral palsy, intellectual disabilities and others. Even babies born just a few weeks early have higher rates of hospitalization and illness than full-term infants. Premature births can result in a number of health issues for children, including developmental disabilities, hearing loss and cerebral palsy, according to the CDC. This can have long-lasting financial effects and can affect a person's education and ability to work. It can also bring economic hardships for parents through added medical costs. In 2007, the Institute of Medicine reported that the cost associated with premature birth in the United States was \$26.2 billion each year.

In Montana, the rate of women smoking is 21 percent; and the rate of uninsured women is 23.1 percent. These factors contribute to improved infant health in Montana. The March of Dimes attributed the improved rates to an expansion of suc-

## RECOMMENDATIONS

Montana's rates of prematurity, low birth weight, and neonatal mortality are slightly lower than the Healthy People 2020 (HP 2020)<sup>2</sup> targets, and our post-neonatal mortality is only slightly higher than the HP 2020 target. Nevertheless, these **rates can be improved.**

- ❑ **Nearly one third of Montana mothers enter prenatal care later than the first trimester.** Early and frequent prenatal care is essential to reduce low birth weight, prematurity, and many complications of pregnancy that may threaten mother or infant.
- ❑ **16% of Montana mothers reported smoking during pregnancy,** increasing the risk for prematurity, low birth weight, and infant mortality, especially from SIDS. Pregnant women who smoke and those planning to become pregnant should be referred to the Montana Quit Line at <http://www.dphhs.mt.gov/mtupp/quitlinefactsheet.shtml>
- ❑ Some causes of neonatal mortality are preventable. For example, **adequate folic acid intake** before conception and in early pregnancy reduces the risk of neural tube defects. This underscores the importance of pre-conceptual planning and health care.
- ❑ Many post-neonatal deaths are potentially preventable, especially those from SIDS and unintentional injuries. **All new parents should receive education about SIDS prevention, promoting safe sleep practices, Shaken Baby Education (AHT/SBS) and breastfeeding,**

For more information about Vital Statistics in Montana, contact Bruce Schwartz, MA, MPA, Lead Vital Statistics Epidemiologist, at [bschwartz@mt.gov](mailto:bschwartz@mt.gov) or 406-444-1756

## PREVENTION OPPORTUNITIES UNDER THE BIG SKY—

### Born in Montana: Birth Facts Quiz

Vital Statistics are a fundamental source of public health and epidemiologic data. The Montana Department of Public Health and Human Services has maintained vital records for Montana since 1907. These data help identify and quantify health burdens experienced by Montanans and predecessor state agencies and help track progress in improving health.

**The following 12 questions highlight infant health concerns in Montana, and are based on information from birth certificates for babies of Montana-resident mothers who gave birth in the five-year interval 2008-2012.**

**1. Approximately how many babies are born to Montana mothers each year?**

- a. 5,000                      b. 12,000                      c. 16,000

**2. About what proportion of new mothers entered prenatal care in the first trimester?**

- a. 70%                      b. 35%                      c. 50%

**3. Approximately what proportion of new mothers reported consuming alcohol during pregnancy?**

- a. 25%                      b. 20%                      c. 1%

**4. Approximately what proportion of new mothers smoked during some part of their pregnancy?**

- a. 5%                      b. 16%                      c. 40%

**5. Approximately what was the rate of prematurity (< 37 weeks gestation) among newborns?**

- a. 10% of live births    b. 15% of live births    c. 20% of live births

**6. Approximately what was the rate of low birth weight (<2500 grams or 5.5 pounds) in newborns?**

- a. 7% of live births    b. 9% of live births    c. 11% of live births

**7. What was the rate of neonatal mortality (< 28 days after birth)?**

- a. 2.3 per 1,000 live births    b. 3.6 per 1,000 live births    c. 12.0 per 1,000 live births

**8. What was the most common cause of neonatal mortality?**

- a. congenital malformations, deformations, and chromosomal abnormalities  
b. sudden infant death syndrome                      c. disorders related to short gestation and low birth weight

**9. What was the rate of post-neonatal infant mortality (29-364 days)?**

- a. 2.4 per 1,000 live births    b. 3.6 per 1,000 live births    c. 12.0 per 1,000 live births

**10. What was the most common cause of post- neonatal infant mortality?**

- a. congenital malformations, deformations, and chromosomal abnormalities  
b. sudden infant death syndrome                      c. disorders related to short gestation and low birth weight

## PEDIATRIC TRAUMA - ARE YOU READY?

Join experts from around the country on **December 16, 2016 11:00-2:30 Mountain Standard Time** as they discuss various methods to **treat and manage the pediatric trauma patient**. Topics covered will include global injury burden, pediatric emergency readiness, trauma system, solid organ management, pancreatic injury management and DVT prophylaxis. The symposium will be broadcast live to a virtual audience from Cincinnati OH. This 4 hour symposium will be based on speaker presentations and a faculty panel discussion. This will be an interactive and engaging seminar with audience polling, questions and debate.

Approved for 3.50 AMA PRA Category 1 Credit

Price: **\$49.00 (group rates available)** Register at <http://www.globalcastmd.com/shows/register/pediatric-trauma-are-you-ready>

### Topics Covered

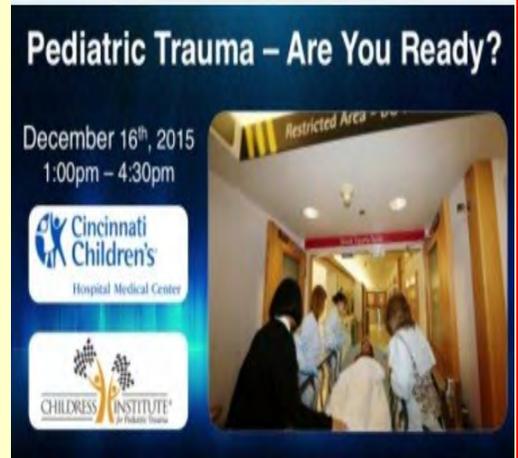
Experts from around the county will be discussing various methods to treat and manage the pediatric trauma patient. Topics covered will include global injury burden, **pediatric emergency readiness, trauma system**, solid organ management, pancreatic injury management and DVT prophylaxis. The symposium will be broadcast live to a virtual audience from Cincinnati OH. This **4 hour symposium will be based on speaker presentations and a faculty panel discussion**.

Accreditation Statement -Cincinnati Children's Hospital Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Cincinnati Children's designates this live activity for a maximum of 3.5 *AMA PRA Category 1 Credit (s)*™.

The agenda times are on Eastern Standard Time (need to adjust for MST)

### AGENDA

- |                   |   |
|-------------------|---|
| 1:00 pm - 1:15 pm | Global Injury Burden - Benedict Nwomeh, MD, MPH <b>(11:00 am MST)</b>                           |
| 1:15 pm - 1:30 pm | Pediatric Emergency Readiness- Elizabeth Edgerton, MD, MPH                                      |
| 1:30 pm - 1:45 pm | Trauma System -Todd Maxson, MD  |
| 1:45 pm - 2:30 pm | Panel Discussion/Q&A  |
| 2:30 pm - 2:45 pm | Break   |
| 2:45 pm - 3:15 pm | Solid Organ Management -(with discussion) David Mooney, MD, David M. Notrica, MD, FACS, FAAP    |
| 3:15 pm - 3:45 pm | Pancreatic Injury Management -(with discussion) Bindi Naik-Mathuria, MD and Shawn St. Peter, MD |
| 4:15 pm - 4:45 pm | Summary & Final Thoughts  |



# Pediatric Trauma - Are You Ready

## LOW-COST BLOOD TEST GOOD PREDICTOR OF INCREASED BLEEDING RISK IN PEDIATRIC TRAUMA PATIENTS

A team of researchers from the Trauma Program at Children's Hospital Los Angeles conclude that an admission hematocrit provides a reliable screening test for identifying pediatric patients who are at an increased risk of bleeding after injury. Their retrospective review of approximately 1,340 trauma patients, ages 0 to 17 years, will be published in the *Journal of Trauma and Acute Care Surgery* and is currently available on PubMed.

Hematocrit is a blood test that measures the percentage of the volume of whole blood that is made up of red blood cells. This measurement depends on the number and size of red blood cells. **Contrary to earlier medical teachings, adult trauma studies have shown a drop in hematocrit can occur immediately after injury - predicting ongoing occult, or non-obvious, blood loss.** To date, the use of hematocrit in triaging bleeding pediatric trauma patients had not been investigated. In examining the patient medical records of all patients who presented to the level 1 pediatric trauma center at CHLA between 2005 and 2013, the researchers found that an admission hematocrit of **-35 was able to identify children who required an intervention -either transfusion or operation - for bleeding, up to 67 hours after arrival.**

**Unintentional injury from trauma is the leading cause of death in children older than one year of age.** Because **young children can be far more difficult to assess clinically** than adults, identifying their injuries and assessing blood loss in these patients is more challenging, requiring resources including advanced imaging, inpatient observation and serial blood tests. Identifying pediatric intra-abdominal injury (IAI) is especially difficult, according to the CHLA researchers. Computed tomography (CT) scans are often used to evaluate patients, but these involve radiation exposure and increased cost.

The results of the study showed a significant difference in admission hematocrit between patients who subsequently required a transfusion and those who did not. The cutoff figure of **-35** had a 94 percent sensitivity, 77 percent specificity and nearly 100 percent negative predictive value. **This led the researchers to conclude that use of this cutoff provides a reliable screening tool, due to its low false negative rate and high specificity for identifying those at increased risk of bleeding.**

Admission hematocrit can be done rapidly in the trauma bay, is relatively inexpensive, causes minimal harm and can aid in critical decision-making and rapid identification of occult bleeding. **Our results show that a hematocrit level of less than 35% on admission predicts a greater likelihood for the need of transfusion in pediatric blunt trauma patients,"** said first author Jamie Golden, MD, a research fellow at CHLA.

The physicians noted that while a doctor's concern in the face of clinical signs of hemorrhagic shock should always take priority over lab data, a repeat hematocrit can be quickly and easily performed if clinically indicated. They added that the results of their study, conducted retrospectively at a single site, require validation in a prospective, multicenter study.

## VERY COOL FACTS ABOUT THE HUMAN BODY

**Sneezes regularly exceed 100 mph.** There's a good reason why you can't keep your eyes open when you sneeze—that sneeze is rocketing out of your body at close to 100 mph. This is, of course, a good reason to cover your mouth when you sneeze.

**Coughs clock in at about 60 mph.** Viruses and colds get spread around the office and the classroom quickly during cold and flu season. With 60 mph coughs spraying germs far and wide, it's no wonder.

**A baby's head is one-quarter of its total length, but by age 25 will only be one-eighth of its total length.** As it turns out, our adorably oversized baby heads won't change size as drastically as the rest of our body. The legs and torso will lengthen, but the head won't get much longer.

**Babies are born with 300 bones, but by adulthood the number is reduced to 206.**

The reason for this is that many of the bones of children are composed of smaller component bones that are not yet fused like those in the skull. This makes it easier for the baby to pass through the birth canal. The bones harden and fuse as the children grow.



To view more facts see [http://icantseeyou.typepad.com/my\\_weblog/2008/02/100-very-cool-f.html](http://icantseeyou.typepad.com/my_weblog/2008/02/100-very-cool-f.html)

## PRE-PLANNING IMPORTANT FOR FARM EMERGENCIES

Farms are full of complex machinery and equipment that can be very deadly, and anyone without a farming background would likely be out of their realm around such equipment. Emergency responders living in heavily agricultural states know how brutal farm accidents can be.

**Pre-planning for farm-related emergencies** will save time, save lives and property, and will protect the emergency personnel.

Firefighters and EMS personnel responding to a farm emergency shouldn't need to take vital time out of the call to learn about the workings of the equipment, bins, silos, or product involved. This can turn a short rescue into an hours-long ordeal and shorten the likelihood of success.

The [Penn State Agricultural Extension's Farm Emergencies program](#) targets these kinds of emergencies. **Training for first responders includes modules on farm confined space, managing farm chemicals, animal emergencies, and grain elevator and feed mill fires. The site lists several helpful brochures and flyers, case studies of the training's impact, and emergency first aid care for farmers\_modules.** (Source: [Penn State Agricultural Extension](#))

## Agro–Security and Agro–Emergency Preparedness

A Montana State University program seeks to assist agricultural producers in preparing for all emergencies, as well as identifying where to get assistance during and after an event. Emergencies could be the result of bad weather, natural disasters, disease outbreaks, transportation accidents, or as a result of deliberate and malicious acts. In any case, a quick organized response to an emergency event will help protect human health and life while reducing or preventing animal disease and death, crop and facilities damage and economic loss. <http://www.animalrangeextension.montana.edu/agrosec/agrosec.html>

## SCREENING FOR MENTAL HEALTH ISSUES IN A PEDIATRIC ED

In a study that was published on Oct. 1 by the **journal *Pediatric Emergency Care***, investigators at Children's Hospital Los Angeles (CHLA) piloted a brief mental health screening tool to be used with patients accessing the emergency department for medical complaints who might be at risk for mental health problems. Of the 992 patients studied, nearly half (47.5%) responded "yes" to questions about substance abuse, traumatic exposure or behavioral symptoms such as depression and anxiety.

In the U. S., 1 in 10 children and adolescents suffer from mental illness, yet only 1 in 5 receive mental health services. **Many undiagnosed mental health conditions can lead to chronic medical conditions that interfere with a child's normal development and functioning.** Based on recommendations from organizations, literature and research, it is becoming clear that identifying mental health needs is part of quality medical care. **The emergency department is the ideal place for that assessment to occur.**

This retrospective study was based on a previous quality improvement project that assessed mental health issues among English-speaking patients, 12 years of age or older. Interviews were conducted by physicians in the privacy of the patient's room, without parent or caregiver present. **Patients were asked to answer 11 yes/no questions that covered a range of mental health issues including hyperactivity, exposure to domestic violence, drug and alcohol use, bullying and thoughts of suicide.**

"By embedding mental health screening in the emergency department, we are making it part of our health care culture -- reducing the stigma associated with mental health problems and providing the opportunity for early identification and treatment for all children," said Jeffrey I. Gold, PhD, director of the Children's Outcomes, Research and Evaluation program at CHLA and an author on the study.

<http://www.chla.org/press-release/screening-mental-health-issues-pediatric-ed>



## **CHILD READY MONTANA**

**Child Ready Montana** is a State Partnership Regionalization of Care Grant (SPROC) funded by the Federal Health Resource and Services Administration (HRSA). Montana is one of 6 states to be awarded this grant with the Montana Emergency Medical Services for Children (EMSC) Program.

### **REVISED AND APPROVED BY THE ACEP BOARD OF DIRECTORS "PRINCIPLES OF APPROPRIATE PATIENT TRANSFER"**

The American College of Emergency Physicians (ACEP) believes that quality emergency care should be universally available and accessible to the public. For patients evaluated or treated in the emergency department (ED) who require transfer from the ED to another facility, **ACEP endorses the following principles regarding patient transfer.**

The optimal health and well-being of the patient should be the principal goal of patient transfer. Emergency physicians and hospital personnel should abide by applicable laws regarding patient transfer. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer. If a competent patient requests transfer before the completion of the MSE and stabilizing treatment, these should be offered to the patient and documented. Hospital policies and procedures should articulate these obligations and ensure safe and efficient transfer.

The transferring physician should inform the patient or responsible party of the risks and the benefits of transfer and document these. Before transfer, patient consent should be obtained and documented whenever possible.

The hospital policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital will use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care provided during transfer, and the destination of the patient. Transfers are effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a hospital with the capability and capacity to provide a higher level of care may not refuse any request for transfer.

An appropriate medical summary and other pertinent records should accompany the patient to the receiving facility or be electronically transferred as soon as is practical.

**When transfer of patients is part of a regional plan to provide optimal care at a specialized medical facility, written transfer protocols and interfacility agreements should be in place.**

The Emergency Medical Treatment and Active Labor Act, as established under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 USC 1395 dd) and 42 CFR 489.24; 42 CFR 489.20 (EMTALA regulations). —[www.acep.org/MobileArticle...](http://www.acep.org/MobileArticle...)

Kassie Runsabove  
406-238-6216

[Kassie.runsabove@sclhs.net](mailto:Kassie.runsabove@sclhs.net)

## CHILDREN AND HAND SANITIZERS- CAUTION REQUIRED!

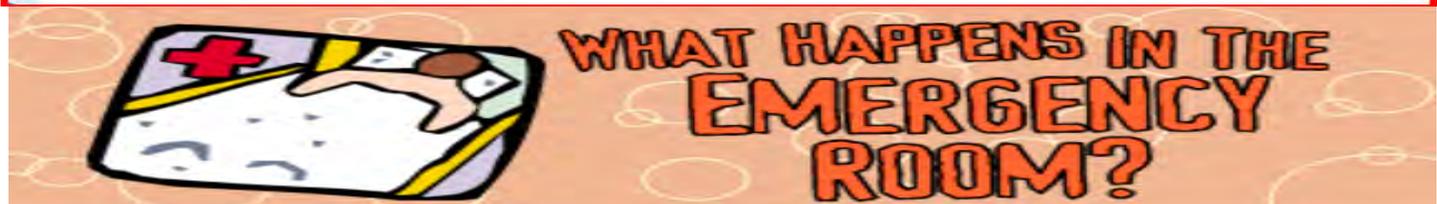
Poison control centers have seen a nearly **400 percent jump in calls** related to children under 12 ingesting hand sanitizer since 2010. Calls increased from 3,266 in 2010 to 16,117 last year. The findings come from an analysis by the Georgia Poison Center. "Kids are getting into these products more frequently, and unfortunately, there's a percentage of them going to the emergency room," Dr. Gaylord Lopez, the center's director, told CNN.

**The amount of alcohol in hand sanitizer can vary from 45 percent to 95 percent, the article notes. In contrast, wine contains about 12 percent alcohol, while beer contains about 5 percent. In some cases, ingesting as little as two to three squirts of hand sanitizer can cause alcohol poisoning.** A child with alcohol poisoning from hand sanitizer can **experience confusion, vomiting and drowsiness.** A child with a severe case of alcohol poisoning can stop breathing.

Children ingest hand sanitizer for a variety of reasons. They may be trying to get drunk, doing it on a dare, or drinking it because it looks like it would taste good. "A kid is not thinking this is bad for them," Lopez said. "A lot of the more attractive (hand sanitizers) are the ones that are scented. The **strawberry, grape, orange-flavored hand sanitizers** are very appealing to kids. He advises parents and teachers to store hand sanitizer in a place where children cannot reach it, and monitor its use. **Sanitizing wipes or non-alcohol based products are alternatives to hand sanitizers.**



The screenshot shows a website page with a green header. On the left is a cartoon illustration of a white ambulance with a red cross on its side. To the right of the illustration, the text "GOING TO THE HOSPITAL" is written in large, blue, bubbly letters. Below the header, there is a breadcrumb trail: "KidsHealth > Kids > People, Places & Things That Help > Places > Going to the Hospital". To the right of the breadcrumb trail are icons for "Text Size" (AAA) and "Print". Below the breadcrumb trail is a search bar with the text "What's in this article? (click to view)". Below the search bar is a "Listen" button with a speaker icon. Below the "Listen" button is a paragraph of text: "You might go to the hospital if you fall off your bike and break your arm or if you have asthma and have trouble breathing. You might go to the hospital if you become dehydrated and need IV fluids or if you need to have surgery to take out your tonsils." To the right of this paragraph is a button that says "Lee este artículo en Español" with a play icon. Below the paragraph is another paragraph: "It may seem a little scary to go to a hospital, but doctors, nurses, and other hospital workers are there to help people who are sick or hurt feel better. Read on to find out what happens inside a hospital."



This section features a cartoon illustration of a person lying on a hospital gurney, being pushed by a person in a white coat. The gurney has a red cross on its side. To the right of the illustration, the text "WHAT HAPPENS IN THE EMERGENCY ROOM?" is written in large, orange, bubbly letters.

For Kids

### MORE ON THIS TOPIC

- ▶ [Going to the Hospital](#)
- ▶ [What Happens in the Operating Room?](#)
- ▶ [Getting a Urine Test \(Video\)](#)
- ▶ [Checking Out Cuts, Scratches, and Abrasions](#)
- ▶ [Getting a Blood Test \(Video\)](#)
- ▶ [The Facts About Broken Bones](#)
- ▶ [Why Do I Have Pain?](#)

[http://kidshealth.org/kid/feel\\_better/places/hospital.html](http://kidshealth.org/kid/feel_better/places/hospital.html)



# TRIVIA CONTEST:

The facility who has at least two people answer the trivia will win a free registration to the December 16th "Pediatric Trauma: Are You Prepared? Symposium. The symposium will be broadcast live to a virtual audience from Cincinnati Ohio. Email answers to Robin @ rsuzor@mt.gov

1. What grade did Montana receive on the 2013 March of Dimes Report Card?
2. How many bones is a baby born with?
3. Approximately how many babies are born to Montana mothers each year?
4. Approximately what proportion of new mothers reported consuming alcohol during pregnancy?

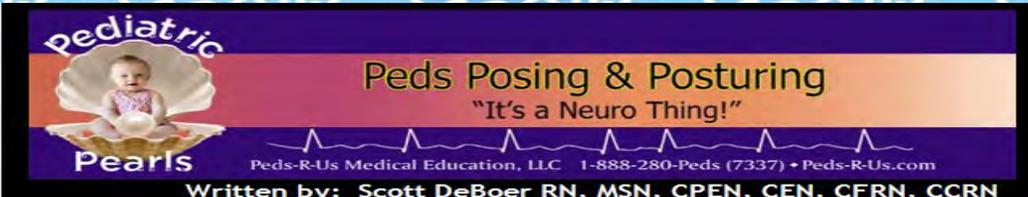
## TRAINING RESOURCES: check out these you tube video trainings!

### SPECIAL PATIENT POPULATIONS: THE PEDIATRIC PATIENT

## COGNITIVE OBJECTIVES

- \* Explain Why Pediatric Patients Need Varying Approaches To Assessment and Care
- \* Identify the Developmental Considerations For the Following Age Groups:
  - ♥ Infants, Toddlers, Pre-School, Middle Childhood, and Adolescent
- \* Consider the Metabolic Differences In Providing Care To the Pediatric Patient
- \* Identify the Anatomical and Physiological Differences To Consider In the Care Of the Pediatric Patient In the Following Areas:
  - ♥ Head, Airway, Chest, Lung, Abdomen, Extremities, Integumentary System, Respiratory System, Circulatory System, Nervous System, and Spinal Column





**Written by: Scott DeBoer RN, MSN, CPEN, CEN, CFRN, CCRN**



Learn Pediatrics: Newborn Exam by Creativeness 50,364 views



**Monday Minutes**

**Pediatric  
Respiratory  
Problems**



**Peds R Us**  
Medical Education, L.L.C.



<https://www.youtube.com/watch?v=ZsP8Obqbwfl>

9052 Beall Street, Dyer, IN 46311  
1-888- 280-Peds(7337) \* [www.peds-r-us.com](http://www.peds-r-us.com) \* [Education@Peds-R-Us.com](mailto:Education@Peds-R-Us.com)

