DEMOGRAPHIC & INSURANCE INFORMATION
ASSIGNMENT OF BENEFITS; RELEASE OF INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Today's Date: _____

Patient Name: _____ _____
Last First

Date of Birth: ____/____/____ Male:____ Female: ____
Month/Day/Year

Mother:_____ Date of Birth: _____

Father:_____ Date of Birth: _____

Telephones: home:_____cell: _____other: _____

Address: _____Zip: _____

Email: _____

Primary Physician:_____ *tel:* _____ *fax:* _____

Pharmacy Name: _____ Phone: _____

Insurance *Carrier:* _____*ID Number:* _____*;COPAY*_____
Policy/Group: _____
Subscriber's Name: _____ Relationship: _____
Date of Birth:_____
Employer's Name: _____ Work Telephone: _____
Do You Have A Secondary Insurance? Yes____ No____ Initial_____

1. All co-pays and deductibles are due prior to treatment. _____
2. If you're insurance or other pertinent personal information changes, please notify us as soon as possible. _____
3. For insurances we participate with, we will accept assignment of insurance benefits. _____
4. I/we hereby agree to accept full financial responsibility for the following medical care which is a non-covered service based on my current insurance benefits. _____
5. Payment for Excluded Services is due on day of service. _____
6. Payment for telephone consults is due at time of service._____
7. We cannot provide medical services to minor patients without the presence of their parent or legal guardian._____
8. Please help us serve you better by keeping scheduled appointments. Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments. _____

I/We acknowledge and agree that I/We have received a copy of Dr. Mavunda's Notice of Privacy Practices
I/We hereby authorize payment directly to Dr. Mavunda for all insurance benefits payable for professional services rendered. I/We authorize Dr. Mavunda and her staff to release requested information for payment of benefits, and to use the signature(s) below on all insurance submissions.
I/We certify this information is true and correct.

Guarantor's Name: _____

Signature: _____

PEDIATRIC PULMONARY CENTER
Kunjana Mavunda, M.D., M.P.H.
6280 SW 72ND ST. SUITE 607
SOUTH MIAMI, FL 33143

Patient's Name_____ Date Of Birth _____

Please list the reasons for today's visit:

When was your child last seen by the pediatrician? _____

Has your child ever been to the emergency room? _____
If yes, please list which hospital, when, and why they were hospitalized:

Has your child ever had any serious illness or operations? If yes, please describe:

Is your child taking any medications? If yes, please list:

Does your child have any allergies? If yes, please describe:

Has your child had all their necessary immunizations? Yes_____ No_____

Does anyone in your family have any of the following conditions? Please check all that apply:

___Asthma
___Sinus Problems
___Cystic Fibrosis
___Reflux
___Ulcers
___Respiratory Problems
___Pneumonia
___Tuberculosis
___Skin Problems
___Allergies

Please list any other concerns or questions you may have:

Your Signature _____ Today's Date _____

DEMOGRAPHIC & INSURANCE INFORMATION
ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Fecha: _____

Nombre del Paciente: _____ _____
Apellido Primer Nombre

Fecha de Nacimiento: ____/____/____ Maculino:____ Femenino: ____
Mes / Dia / Ano

Nombre de la Madre:_____ Fecha de Nacimiento: _____

Nombre del Padre:_____ Fecha de Nacimiento: _____

Telefono: Casa:_____ Celular: _____ Otro: _____

Direccion: _____ Ciudad: _____ Codigo Postal: _____

Direccion del Correo Electronico:_____

Nombre del Medico de Cabecera:_____ Tel: _____Fax: _____

Nombre de la Farmacia: _____Tel: _____

Nombre del Seguro Medico: _____ ID #: _____;Copago_____
Grupo: _____
Nombre del Asegurado: _____ Parentesco: _____
Fecha de Nacimiento del Asegurado:_____

Empresa donde trabaja: _____ Telefono: _____
Tiene otro seguro medico? Si_____ No _____ Iniciales _____

Por medio de la presente autorizo el pago directo a la Dra. Mavunda de todas las prestaciones del seguro a pagarse por los servicios profesionales prestados. Entiendo que asumo la responsabilidad financiera respecto a todos los cargos, tanto aquellos amparados por el seguro como aquellos que no lo estan.

Autorizo a la Dra. Mavunda y a su personal para divulgar la informacion pertinente para el pago de las prestaciones. Autorizo el uso de esta firma para todos los documentos presentados a la empresa de seguros.

He leido toda la informacion que aparece en ambas caras de esta planilla he completado las respuestas anteriores. Certifico que la informacion suministrada es fiel y correcta segun mi leal saber y entender. Les notificare de cualquier cambio en mi estado o respecto a la informacion anterior.

Nombre: _____ Firma:_____

Fecha: _____

Indique las razones para la visita de hoy: _____
_____

Historia Clinica

1. ¿Cuando fue la ultima visita de su hijo/hija al pediatra? _____
2. ¿ Su hijo o hija ha estado alguna vez en la sala de urgencias? Si____ No____
   En caso afirmativo, indique fecha y razon: _____
   _____
3. ¿ Su hijo o hija ha estado alguna vez hospitalizado? Si_____ No_____
   En caso afirmativo, indique fecha, razon y hospital: _____
   _____
4. ¿ Su hijo o hija ha padecido alguna enfermedad grave o se ha sometido a operaciones?
   Si_____ No _____
   En caso, favor explique: _____
   _____
5. ¿ Su hijo o hija esta tomando algun medicamento actualmente? Si ____ No____
   En caso afirmativo, indique cuales: _____
   _____
6. ¿ Su hijo o hija ha tenido alguna reaccion alergica? Si____ No _____
   En caso afirmativo, indique a que: _____
   _____
7. ¿ Su hijo o hija ha recibido todas las vacunas necesarias? Si_____ No _____
8. ¿ Algun miembro de su familia padece de:

Asma	Si____	No ____
Alergias	Si ____	No ____
Problemas de sinusitis	Si____	No_____
Neumonia	Si ____	No _____
Fibrosis cistica	Si ____	No _____
Reflujo gastrico	Si ____	No _____
Ulceras	Si ____	No _____
Tuberculosis	Si ____	No _____
Problemas de la piel	Si ____	No _____
Problema respiratorio	Si ____	No _____

Alguna otra condicion
En caso afirmativio, favor de explicar: _____
_____

Firma: _____ Fecha: _____

KUNJANA MAVUNDA,MD,MPH – DBA
PEDIATRIC PULMONARY CENTER &
INTERNATIONAL TRAVEL CLINIC

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

s Notice describes how health information about you or your ld (herein after referred to as "you" or "your") may be used l disclosed and how you can access this information. Please iew it carefully.

If you have any questions about this Notice, please contact our vacy Officer at 4625 Ponce de Leon Blvd., Coral Gables, Fl 33146; tel: (305)668-0075

OUR COMMITTMENT TO YOUR PRIVACY

understand that information about you and your health is very personal and are committed to protecting the privacy of this information. Each time you t Dr. Kunjana Mavunda's office, we create a record of the care and services receive. This record is necessary to provide you with high quality care and to ure we are in compliance with certain legal requirements. This Notice applies ll of your health information in our custody.

is Notice will describe the ways in which we may use and disclose your dical information. We reserve the right to change the terms of this Notice at time. Any revision to this Notice will be applicable to all medical rmation we already have about you, as well as any of your medical ormation that we may receive, create, or maintain in the future. We will post a py of our current Notice in prominent locations in each of our practice ations. A copy of the current Notice in effect will be available from the ctice receptionist.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

e following categories describe different ways that we use your health ormation within Dr. Kunjana Mavunda's offices and disclose your health ormation to persons and entities outside of Dr. Kunjana Mavunda's offices. ch description is of a category of uses or disclosures. We have not listed every e or disclosure within the categories, but all permitted uses and disclosures will ll within one of the following categories.

Treatment – We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to doctors, nurses, pharmacists, technicians, medical students, interns, or other personnel who are involved in taking care of you before and during your visit with us.

Payment - We may use and disclose health information about you so the treatment and services you receive at Dr. Kunjana Mavunda's offices may be billed to and payment collected from you, an insurance company or a third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan.

Healthcare Operations - We may use and disclose health information about you for healthcare operations, including quality assurance activities; granting medical staff credentials to physicians; administrative activities, including Dr. Kunjana Mavunda's financial and business planning and development; customer service activities, including investigation of complaints; and certain marketing and fundraising activities, etc. These uses and disclosures are necessary for Dr. Kunjana Mavunda and her staff to ensure all of our patients receive quality care.

Appointment Reminders. We may use your health information to contact you as a reminder that you have an appointment for treatment or medical care.

Family Members and Friends. We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if family members are in the exam room with you, we will assume that you agree to our disclosure of your information in their presence.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic.

We also may share your health information with a family member or friend who calls us to request a prescription refill for you, or to reschedule an appointment.

Note: In order to protect the patient's personal and medical information, we require that you provide us with the patient's social security number. Dr. Mavunda's offices will use this as an additional identifier to confirm that the person we are communicating with is allowed to discuss the patient's information.

The parent or legal guardian must be present with the child who has an appointment with Dr. Mavunda's office.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR AUTHORIZATION

The following disclosures of your health information are permitted by law with-out any oral or written permission from you:

Organ and Tissue Donation - If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans - If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation - We may release health information about for worker's compensation or similar programs if you have a work relate injury. These programs provide benefits for work related injuries.

Averting a Serious Threat to Health or Safety - We may use and/or disclose health information about you when necessary to prevent a serious threat to your health or safety or the health and safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities - We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications, problems with products or other adverse events.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities - We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor

: healthcare system, government programs and compliance with civil rights ws.

awsuits and Disputes - If you are involved in a lawsuit or a dispute, we ay disclose health information about you in response to a court or ministrative order. We may disclose health information about you in response a subpoena, discovery request or other lawful process by someone else volved in the dispute.

aw Enforcement - We may disclose health information if asked to do so by w enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of a criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

oroners, Medical Examiners and Funeral Home Directors - We ay disclose health information to a coroner or medical examiner. This may be cessary to identify a deceased person or determine the cause of death of a rson. We may also release health information about patients at our facility to neral home directors as necessary to carry out their duties.

ational Security and Intelligence Activities - We may disclose health formation about you to authorized federal officials for intelligence, unterintelligence and other national security activities authorized by law.

mates - If you are an inmate of a correctional institution or under custody of a w enforcement official, we may disclose health information about you to the rrectional institution or the law enforcement official. This is necessary for the rrectional institution to provide you with healthcare, to protect your health and fety and the health and safety of others, or for the safety and security of the rrectional institution

egal Requirements - We will disclose health information about you without ur permission when required to do so by federal, state or local law.

WITH YOUR SPECIFIC WRITTEN "AUTHORIZATION"

ther uses and disclosures of health information not covered by this Notice or the ws that apply to us will be made only with your written permission (called uthorization"). If you authorize us to use or disclose health information about u, you may revoke that authorization in writing at any time. If you revoke your thorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the Dr. Kunjana Mavunda's office, the entity that created it, the information belongs to you. You have certain rights with respect to your information as described below. If you wish to exercise your rights, you may complete preprinted forms at registration or you may write directly to the Privacy Officer.

1. **Right to request a restriction on certain uses and disclosures of your information.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.

2. **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain manner or at a certain location. For example, you may request that we limit our communications with you to contact at work or at home. Your request must be in writing, as described above, and must specify the manner in which or the location at which you wish to be contacted. All reasonable requests will be accommodated.

3. **Right to inspect and/or request a copy of your health record.** You have the right to inspect and/or receive copy any medical information maintained about you that may be used to make decisions about your care. Typically, this will include your medical and billing records but does not include psychotherapy notes.

   In order to inspect and/or receive a copy of your medical information, you must submit your request, in writing to the Privacy Officer. We may charge a reasonable fee for this service based on our cost of complying.

   In very limited circumstances, we may deny your request to inspect and/or receive a copy of your information. However, if your request is denied, in some cases you may request that the denial be reviewed. An independent licensed healthcare professional chosen by the Privacy Officer performs such reviews. We will comply with the outcome of the review.

4. **Right to request an amendment to your health record.** If you believe the information we maintain about you is incorrect or incomplete, you may request that we amend the information. In order to request an amendment, you must submit a written request, as described above, indicating the specific information you wish to be amended and providing the reason supporting the request. Failure to put your request in writing or provide supporting reasoning is likely to result in a denial of your request.

   We may also deny your request if you ask us to amend information that:

   - Is accurate and complete.
   - Is not part of the information that you would be permitted to inspect or receive a copy.
   - Is not part of the medical information maintained by Dr. Kunjana Mavunda's office.
   - Was not created by us, unless the individual or organization that created the information is no longer available to make the amendmer

5. **Right to obtain an accounting of disclosures of your health information.** You have the right to request an accounting disclosures, which is a list of certain disclosures of your medical information made by Dr. Kunjana Mavunda's office other than disclosures allowed or required by law or authorized by you. The request for this accounting must be submitted in writing as described above. Your request must include the time period for wh you are requesting an accounting, which may not exceed six years ar not include dates prior to April 14, 2003. Fees may be imposed as allowed by law.

6. **Right to obtain a copy of this Notice of Information Practices upon request.** We will post a copy of the current notice in our facilities. A copy of the current Notice in effect will be available at the reception area of each facility.

COMPLAINTS OR CONCERNS

You may contact the Privacy Officer if you have a question about this Privacy Notice or about your privacy rights. You should also contact the Privacy Officer if you have a complaint or concern that your rights have been violated.

You may make also write to the Secretary of Health and Human Services

Kidz Pediatric Multispecialty Group
Pediatric Pulmonology & Immunization

School / Work Excuse

Date: _____

TO Whom It May Concern:

Please excuse _____ from _____ school _____ work for an appointment at this office on _____ with Dr. Mavunda.

On date: _____ this patient may

_____ return to regular activity.

_____ participate in sports/physical education.

_____ may not participate in sports/ physical education until _____.

Please call our office if you have any questions 305-668-0248 Monday –Friday from 8:30 am to 4:30 pm. Thank you very much for your cooperation.

Sincerely,

_____

NEBULIZER TREATMENTS AND EQUIPMENT CARE

Preparing the nebulizer

1. Connect one end of the tube to the air compressor and the other end to the nebulizer cup.
2. Open the nebulizer cup.
3. Place the normal saline and medication in the nebulizer cup and close it.
4. Attach the nebulizer cup to the mask or mouthpiece.
5. Turn the air compressor on to start the treatment.

Having the treatment

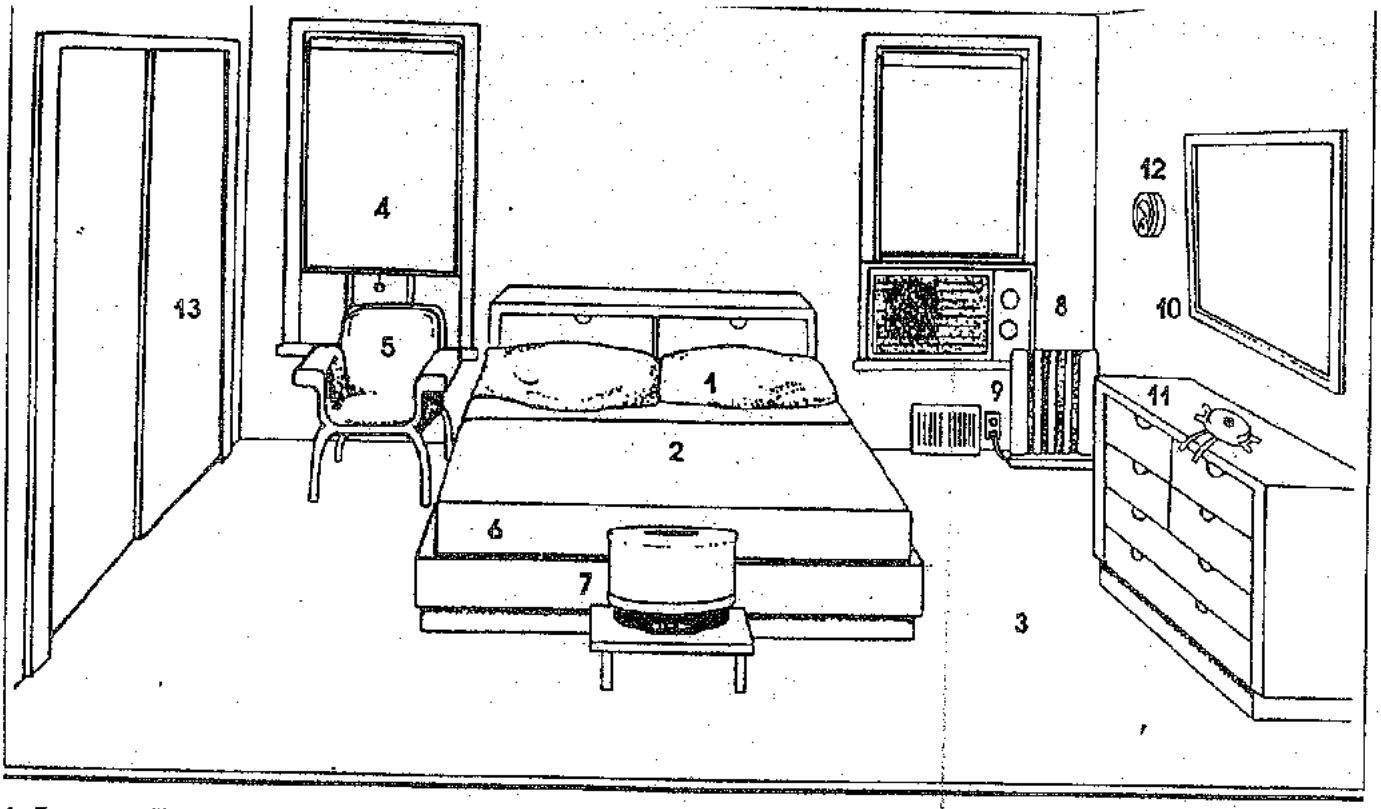
1. Place the mask on the child's face or the mouthpiece in the child's mouth.
2. Tell child to breathe in through the mouth and out through the nose.
3. If mouthpiece is used, lips must form a tight seal around it.
4. The length of the treatment depends on the amount of fluid in the cup.
5. Tap nebulizer cup to make sure all of the medicine droplets are used.

Cleaning the equipment

1. After each treatment, wash nebulizer cup, mask or mouthpiece with warm water and soap.
2. Allow to air dry and store in plastic bag until next treatment is due.
3. Disinfect daily by either: boiling in water x 5 minutes, wash in dishwasher x 30 minutes >158°F, use 70% rubbing alcohol x 5 minutes and rinse with sterile water, or soak in 3% hydrogen peroxide x 30 minutes and then rinse with sterile water.

Helpful Hints

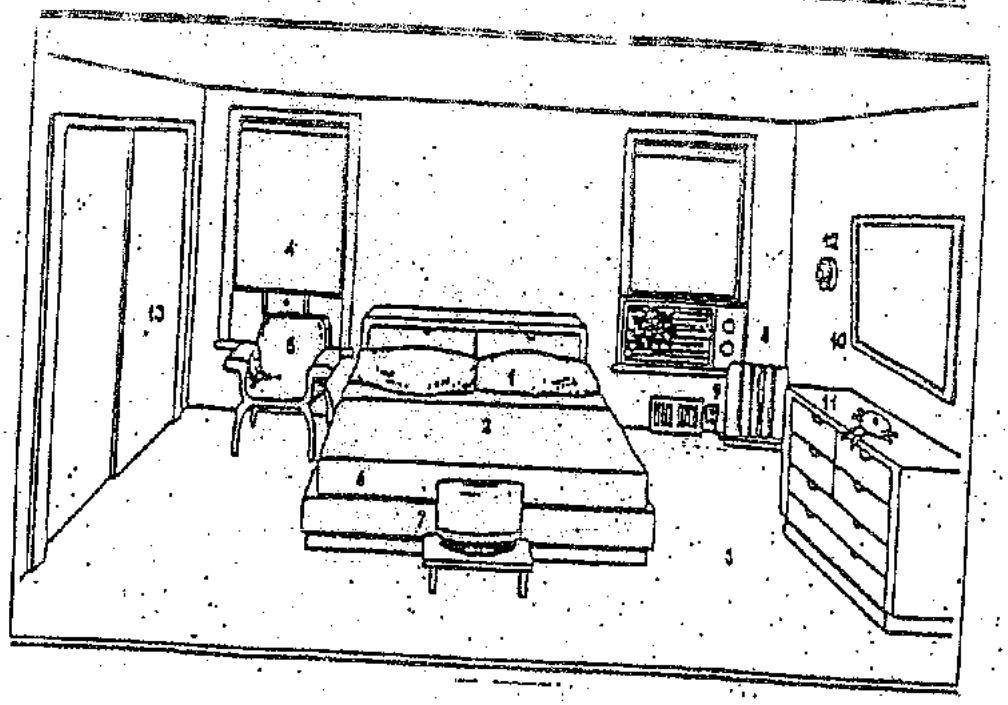
1. To prevent any nausea, give the treatment at least 1 hour before meals or 1 ½ hours after meals.
2. Side effects may include increased heart rate and jitteriness. Immediately after an aerosol treatment, some children may have increased cough and may bring up mucus.
3. It is very important to remember that clean nebulizer equipment helps to prevent lung infections.
4. Nebulizer kits (mask, tubing, mouthpiece, medicine cup) need to be changed for a new one every 10 days. You will need a prescription to purchase replacement kits or to have your insurance company or Medicaid pay for them.



1. Encase pillows in zippered, dust-proof covers.
2. Encase the mattress and box spring in zippered, dust-proof encasings. (If there is more than one bed in the room, all should be encased.)
3. Remove all carpeting. If this is not possible, Allergy Control Solution™may be applied periodically to inactivate dust allergy causing particles.
4. Avoid heavy curtains and venetian blinds. Use window shades instead. If curtains are used, launder them frequently.
5. Substitute wooden or plastic furniture for upholstered furniture.
6. Wash blankets in hot water every two weeks. Avoid wool and down blankets. Vellux® blankets can withstand repeated hot water washings.
7. "H.E.P.A." air cleaners can remove airborne dust particles. Inexpensive table top models are not effective.
8. Air conditioners can prevent the high heat and humidity which stimulate mite growth. Special filters can be added to help trap the air borne allergens. Use a dehumidifier in damp basements.
9. Cover hot air vents with filters, or close the vents and use an electric radiator.
10. Avoid wall pennants, macrame hangings and other dust collectors.
11. Clean drawers and closets with a damp cloth. Wear a face mask when making the bed and doing housecleaning.
12. If using a humidifier in the winter, avoid over-humidification. Mites grow best at 75–80% relative humidity and can not live at under 50% humidity. Use a humidity gauge to maintain relative humidity at 40–50%.
13. Keep all clothing in a closet, with the door shut.

MANY CHILDREN with asthma are allergic to dust or dust mites. Removing the cause of the allergy from their bedrooms may reduce the frequency of asthma attacks, according the Drs. Andrew M. Murray and Alexander B. Ferguson of the University of British Columbia, Vancouver, Canada. The Canadian researchers divided 20 asthmatic children into two groups with similar symptoms in order to compare the effects of a normal and dust-free environment. While one group was not told to make any changes, the other was given zippered vinyl covers for their bedding. They were also instructed to clean the bedroom floor daily with a damp or oiled mop, to launder curtains, blankets and mattress pads every two weeks and to wipe drawers and closets with a damp cloth. Further instructions included removing carpets, upholstered furniture, toys, books and worn clothes from the room. Finally, any hot-air ducts were sealed, and heat provided by an electric radiator if necessary. At the end of the month, children who had eliminated sources of dust reported a total of only 10 hours of wheezing and 5 doses of medication. Youngsters who had made no change in their surroundings had had a total of 339 hours of wheezing and had required 224 doses of medication. Pediatrics: Vol. 71, page 418.

Allergy Control Products Inc. • 96 Danbury Road • Ridgefield, CT 06877



1. Las almohadas deben tener un forro que tenga una cremallera (cierre) y que sea a prueba de polvo.
2. Debe poner el colchon dentro de una bolsa a prueba de polvo y que se pueda cerrar con una cremallera (cierre), necesita cubrir el cierre con una cinta adhesiva que sea bastante fuerte para que no se despegue facilmente. Trate todos los colchones en el cuarto de la misma manera.
Esto se recomienda para evitar exponerse a las pulgas del polvo que viven en el relleno de las almohadas, colchones, cojines, etc.
3. Si es possible quite la alfombra. Si no puede, debe pasar la aspiradora por lo menos una vez a la semana y cambia la bolsa de la aspiradora regularmente. No permita que las personas que tienen asma esten presentes cuando este pasando la aspiradora.
4. Evite cortinas o verticals que no se puedan lavar o limpiar con un paño humedo. Las cortinas deben lavarse cada tres o cuatro semanas.
5. Es preferable que use muebles plasticos o de Madera a que tenga muebles acolchonados o de tela.
6. Lave la ropa de cama una vez por semana en agua caliente y seque en la secadora a temperatura alta. No debe usar colchas o cobijas de lana o edredones que esten rellenos con plumas.
7. Existen filtros de aire que pueden remover particulas de polvo, los modelos que son mas eficientes estan identificados como "H.E.P.A."
8. Las unidades de aire acondicionado ayudan a reducir la humedad y el calor que pueden facilitar el crecimiento de las pulgas del polvo. Debe cambiar o lavar el filtro del aire acondicionado una vez al mes.
9. Los salideros del aire deben estar limpios y si es possible cubiertos con un filtro.
10. Cuadros, ornamentos de tela y otros objetos que se cuelgan en la pared acumulan polvo y no se puedan limpiar facilmente.
11. Mantenga la superficie de los muebles limpios, si la persona que limpia en la casa padece de alergias, asma u otro problema respiratorio, es aconsejable que use una mascara o pañuelo que cubra la nariz y la boca cuando esta limpiando.
12. Si usa una unidad para proveer humedad al aire dentro de la casa, mantengala graduada para que produzca entre 40 a 50% de humedad relativa, la pulga del polvo se reproduce mas rapido cuando la humedad relativa esta entre 75 al 80%
13. Mantenga la ropa guardada en gavetas o en el closet.

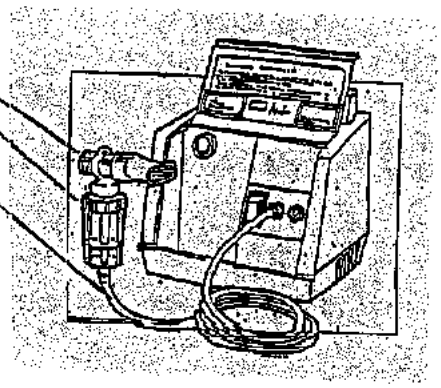
PEDIATRIC PULMONARY MEDICINE

KUNJANA MAVUNDA, M.D., M.P.H.
Board Certified Pediatric Pulmonologist
4625 Ponce de Leon Blvd
Coral Gables, FL 33146

Tel: (305) 668-0075
Fax: (305) 668-6299

TRATAMIENTOS DE AEROSOL

Los tratamientos de aerosol o nebulizacion se utilizan con el proposito de administrar medicinas directamente a los pulmones. La maquina de aerosol consiste de un compresor que produce aire a presion. Cuando este aire a presion pasa por un tubito fino, convierte el liquido en la tacita de la medicina en una lluvia fina que luce como una pequena nube blanca. Es de esta manera que los pulmones pueden beneficiarse de la medicina.



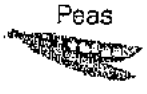
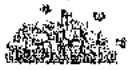
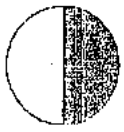
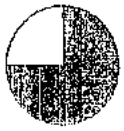
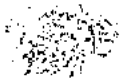
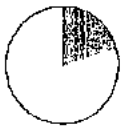
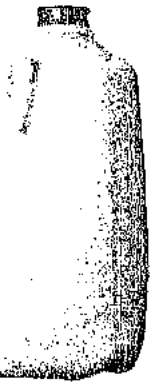
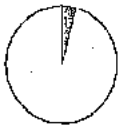
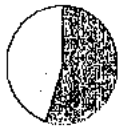
Administracion de medicinas:

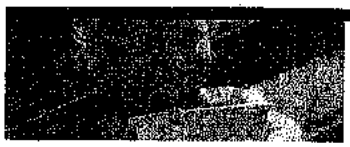
1. Conecte la tacita de la medicina a la canula. La canula la coloca en la salida del aire del compresor.
2. Mida la cantidad exacta de la medicina y deposite en la tacita.
3. Coloque la mascara o pipa en la apertura de la tacita.
4. Active el compresor y cuando vea la nube de medicina coloque la mascara en la cara o la pipa cerca de la nariz y boca.
5. Se debe respirar profundamente hasta que se acabe toda la medicina. La duracion del tratamiento depende de la cantidad de liquido en la tacita.
6. Despues que termine el tratamiento, se debe lavar la cara y enjuage la boca o tome algo liquido.

Limpieza del equipo:

1. Despues de cada tratamiento lave la tacita, la mascara o pipa con agua y jabon.
2. Guarde en una bolsa plastica despues que todo se seque bien.
3. Desinfecte una vez al dia: hierva en agua x 5 minutos, use lavadora de platos x 30 minutos >158°F, sumerja en 70% alcohol x 5 minutos y lave con agua hervida o sumerja en 3% agua oxigenada x 30 minutos y lave con agua hervida.
4. Debe usar un set nuevo (tacita, canula, mascara, pipa) cada 10 dias.

Es muy importante que consulte a su medico si despues del tratamiento se siente muy nervioso, irritado, tiene nauseas, dolores de cabeza, no siente alivio al respirar o siente que necesita usarlo mas de lo que le fue indicado.

If You're Allergic to This	You run the **Risk of Reaction** to at Least One	Risk Percentage
Legumes Peanut 	**Other Legumes** Peas  Beans  Lentils 	5% 
Tree Nuts  Walnut	**Other Tree Nuts**  Brazil  Cashew  Hazelnut	37% 
Fish Salmon 	**Other Fish**  Sole  Swordfish	50% 
Shellfish  Shrimp	**Other Shellfish**  Crab  Lobster	75% 
Grains  Wheat	**Other Grains**  Barley  Rye	20% 
Cow's Milk 	**Beef** 	10% 
Cow's Milk	**Goat's Milk** 	92% 
Cow's Milk	**Mare's Milk** 	4% 
Pollen  Ragweed  Birch	**Fruits/Vegetables**  Honeydew  Apple  Peach	55% 
Peach Peach 	**Other Rosaceae**  Apple  Plum  Pear  Cherry	55%
Melon Cantaloupe	**Other Fruits** Watermelon Banana Avocado	92%
Latex Latex Glove	**Fruits** Kiwi Banana Avocado	35%
Fruits Kiwi Banana Avocado	**Fruits** Latex Glove	11%



WHAT'S UP WITH MY KID'S STOMACH? *(2-12 year olds)*

Reflux and Your Child

Gastroesophageal Reflux (GER) occurs during or after a meal when stomach contents go back into the tube that connects the mouth to the stomach.

Most children are able to decrease their reflux with lifestyle and diet changes:

- ☐ Have your child eat smaller meals more often
- ☐ Avoid eating 2 to 3 hours before bedtime
- ☐ Elevate the head of the bed 30 degrees
- ☐ Avoid carbonated drinks, chocolate, caffeine, and foods that are high in fat (french fries and pizza) or contain a lot of acid (citrus, pickles, tomato products) or spicy foods
- ☐ Avoid large meals prior to exercise
- ☐ Help your child lose weight if he or she is overweight
- ☐ Avoid exposure to tobacco smoke

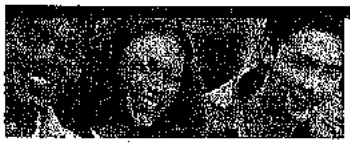
Most children with GER will be helped with the treatment mentioned above. If symptoms are severe or persistent then your primary care provider may consider treatment with a medication or referral to a pediatric gastroenterologist.

Worrisome Symptoms of Reflux Disease in Children (2-12 year olds)

(Symptoms experienced by your child.)

1. Repeated vomiting associated with:
   - Blood
   - Green or yellow fluid
   - Weight loss or poor weight gain
2. Frequent sensation of food or liquid coming up into the back of the throat or mouth
3. Frequent discomfort in the stomach or chest
4. Swallowing problems
   - Discomfort with the act of swallowing
   - Pain with swallowing
   - Sensation that food gets stuck on the way down
5. Breathing Problems
   - Wheezing
   - Chronic cough or recurrent pneumonia
   - Hoarseness
   - Asthma

If you have concerns, speak to your healthcare provider.



SICK AND TIRED OF BEING SICK *(13+ years)*

Reflux and Your Teen

Gastroesophageal Reflux (GER) occurs during or after a meal when stomach contents go back into the tube that connects the mouth to the stomach.

Most teenagers are able to decrease their reflux with lifestyle and diet changes:

- ☐ Have your teenager eat smaller meals more often
- ☐ Avoid eating 2 to 3 hours before bedtime
- ☐ Elevate the head of the bed 30 degrees
- ☐ Avoid carbonated drinks, chocolate, caffeine, and foods that are high in fat (french fries and pizza) or contain a lot of acid (citrus, pickles, tomato products) or spicy foods
- ☐ Avoid large meals prior to exercise
- ☐ Help your teen lose weight if he or she is overweight
- ☐ Avoid cigarette smoking
- ☐ Avoid drinking alcohol

Most teens with GER will be helped with the treatment mentioned above. If symptoms are severe or persistent then your primary care provider may consider treatment with a medication or referral to a pediatric gastroenterologist.

Worrisome Symptoms of Reflux Disease in teenagers (13+Years Old)

(Symptoms experienced by your teen.)

1. Repeated vomiting associated with:
   - Blood
   - Green or yellow fluid
   - Weight loss or poor weight gain
2. Frequent sensation of food or liquid coming up into the back of the throat or mouth
3. Frequent discomfort in the stomach or chest
   - Heartburn
4. Swallowing problems
   - Discomfort with the act of swallowing
   - Pain with swallowing
   - Sensation that food gets stuck on the way down
5. Breathing Problems
   - Wheezing
   - Chronic cough or recurrent pneumonia
   - Hoarseness
   - Asthma

If you have concerns, speak to your healthcare provider.

YOUR SOURCE FOR PEDIATRIC GERD INFORMATION

CDHNF National Office, P.O. Box 6, Flourtown, PA 19031 • Phone: 215-233-0808 Fax: 215-233-3918 • www.KidsAcidReflux.org • www.TeensAcidReflux.org

WWW.CDHNF.ORG • WWW.NASPGHAN.ORG

Educational support for The CDHNF Pediatric GERD Education Campaign was provided by Major Sponsor **TAP Pharmaceutical Products Inc.**

INTERNATIONAL TRAVEL CLINIC
6280 S.W. 72ST., SUITE 607, TEL: (305)668-0075
SOUTH MIAMI, FL 33143 FAX: (305)668-6299

Insect and Mosquito Protection

Insects can cause serious illnesses. There are different modes of transmissions such as when they inject venoms, when they bite or when they land on people or on the foods that people consume.

Recommendations for Reducing Risk :

- Spend time in air-conditioned environments that mosquitoes cannot easily enter.
- Spend time at beaches, where mosquitoes are generally less abundant.
- Avoid highly populated residential areas.
- Minimize outdoor activities when insects are most active. Ticks and mites present in some forested areas or shrubs can also transmit diseases
- Avoid brightly colored clothing and wear clothes that cover most of the body.
- Avoid perfumes, lotions and other scented hygiene products because sweet smells attract insects.
- Do not walk with bare feet. Many biting insects crawl on the ground or fly within several inches of it.
- After long hikes, take a bath and inspect your body for embedded insects.
- Avoid areas near stagnant water and don't swim in small ponds or lagoons.
- Avoid open-air restaurants and outdoor buffets, where food may be exposed to flying insects.
- The most effective ingredient in insect repellant is **DEET**. A concentration of 30% is recommended. **Always use it according to manufacturer's recommendation, particularly on children's skin.**
- 20% **Picaridin** – made from thyme oil is also an effective repellant
- Avoid applying repellents to the hands of young children to avoid eye irritation.
- Never use repellents on wounds or irritated skin.
- Wash treated skin after coming indoors, if there is no risk of exposure to insects.
- Spray or soak your clothing with repellents containing **permethrin**, since mosquitoes bite through thin clothing. Permethrin kills insect but is not toxic to people
- Use mosquito netting over the bed if your bedroom is not air-conditioned or screened. For additional protection, spray the netting with an insecticide containing permethrin. You may also spray your bedroom before going to bed. **It is important to avoid inhaling or ingesting repellents.**

INTERNATIONAL TRAVEL CLINIC
6280 S.W. 72ST., SUITE 607,
SOUTH MIAMI, FL 33143

TEL: (305)668-0075
FAX: (305)668-6299

FOOD & BEVERAGE PRECAUTIONS

BE KIND TO YOUR STOMACH!

" Boil it, cook it, peel it, or forget it"

- If you drink water, buy it bottled or bring it to a rolling boil for 1 minute before you drink it. At high altitudes, boil water for longer.
- Adding a pinch of salt or pouring water from one clean container to another will improve the taste.
- Chemical disinfection can be achieved by using tincture of iodine or tetraglycine hydroperiodide tablets such as Globaline*, Potable-Aqua*, and others.
- Bottled carbonated water is safer than uncarbonated water.
- Drink only from bottles or containers that have not been tampered with.
- Ask for drinks without ice unless the ice is made from bottled or boiled water.
- Avoid popsicles and flavored ices that may have been made with contaminated water.
- Teeth should be brushed with purified water. If it is not available, use hot tap water.
- Make sure utensils are clean.
- CONSUME WELL-COOKED FOODS.
- WASH YOUR HANDS CAREFULLY BEFORE EATING OR PREPARING FOOD.
- Eat foods that have been thoroughly cooked and that are still hot and steaming.
- Do not eat left-overs.
- Avoid cold cuts.
- Avoid raw vegetables and fruits that cannot be peeled. Vegetables like lettuce are easily contaminated and are very hard to wash well.
- When you eat raw fruit or vegetables that can be peeled, peel them yourself. Do not eat the peelings.
- Do not eat canned food if the tin appears 'blown' or "swollen".
- Avoid foods and beverages from street vendors. It is difficult for food to be kept clean on the street, and many travelers get sick from food bought from street vendors.
- Other foods of concern are unpasteurized milk and milk products, raw meat, and shellfish.
- Some fish are not guaranteed to be safe even when cooked because of the presence of toxins in their flesh.

INTERNATIONAL TRAVEL CLINIC
www.internationaltravelclinic.org
e-mail = internationaltravelclinic@gmail.com

TRAVELER'S DIARRHEA

Traveler's Diarrhea may be caused by bacteria, parasites or viruses.
Whatever the cause, it is better to use the bathroom and allow the germs to leave the body, rather than trying to stop it.

Lomotil and/or Immodium should be used with caution. They should be used only when access to the bathroom is not available. If used, the germs that cause diarrhea stay in the body, and can cause further harm. Therefore, an effective antibiotic may be necessary when this medication is used.

Probiotics (available over the counter at pharmacy or Whole Foods) may be helpful in preventing diarrhea. Many types of probiotics are available. They help restore the gastrointestinal tract with beneficial organisms. Because they are natural products, the dose can be increased if symptoms occur.

Travelan is a product that has become available recently in the US. When taken with each meal, this may also help prevent diarrhea.

Peptobismol may be added if diarrhea starts. Peptobismol should be avoided by persons with aspirin allergy, renal insufficiency, gout, and by people taking anticoagulants, methotraxate or probenecid. Using peptobismol preventively on a daily basis is not recommended. However, up to 8 tablets a day can be used to manage diarrhea.

While experiencing diarrhea, the diet should include starchy foods, such as crackers, bread, rice, bananas, carrots, mangoes. Avoid fruit juices.
After the symptoms improve, it will be important to continue this diet for a few days after.

Diarrhea caused by **viruses** tends to profuse and watery, and lasts for 2-3 days.
Diarrhea caused by **bacteria** tends to contain increased mucus, may be explosive and may cause fever and/or abdominal cramps. Antibiotics, such as Alinia, Zithromax, Rifaximin are effective. There is increasing resistance to antibiotics such as ciprofloxacin, levoquin and bactrim.
Diarrhea caused by **parasites** tends to linger, and may be foul smelling, frothy and may vary from being forms to watery and frothy. Medications such as Nitazoxanide and Flagyl may be prescribed to treat.

INTERNATIONAL TRAVEL CLINIC
6280 S.W. 72ST., SUITE 607,
SOUTH MIAMI, FL 33143

TEL: (305)668-0075
FAX: (305)668-6299

MALARIA

Malaria is caused by a parasite that is transmitted from person to person by the bite of an infected **Anopheles** mosquito. These mosquitoes are present in almost all countries in the tropics and the subtropics. Anopheles mosquitoes bite during the nighttime hours, from dusk to dawn. There are different types of the parasite. Symptoms and treatment differ for the different kinds of malaria parasite.

Symptoms of malaria include fever, chills, headache, muscle ache, and malaise. Early stages of malaria may resemble the onset of the flu. Travelers who become ill with a fever during or after travel in a malaria risk area should receive prompt medical attention and should inform their physician of their recent travel history. Malaria symptoms can develop as early as seven days after being bitten by an infected mosquito or as late as several months after departure from a malarious area, after antimalarial drugs are discontinued.

Prevention:
The use of antimalarial drugs and use of personal protection measures against mosquito bites can often prevent malaria. Antimalarial drugs are recommended for travelers who are at risk of developing malaria. These medications are not 100% protective. The medication prescribed will depend on your health, the medications you take, the location you are traveling to and the length of travel.

You have been prescribed the following medication:
Lariam (Mefloquine): ____tablet a week. Start 1-2 weeks before departure, use weekly while traveling, and for 4 weeks after leaving the malarial area.
Malarone(Atovaquone/Proguanil): ____ tablet a day. Start 2 days before arriving to malarial area, use daily while traveling, and for 7 days after leaving the malarial area.
Chloroquine: ____tablet a week. Start 1-2 weeks before departure, use weekly while traveling and for 4 weeks after leaving the malarial area.
Doxycycline: 1 tablet a day. Start 2 days before arriving to malarial area, use daily, preferably at the same time of the day, and for 4 weeks after leaving the malarial area.
Primaquine: may be needed after prolonged stay in malarial area

*** Contact our office if you develop fever or other symptoms after returning from your trip.**