Alternative Sleep Position Waiver

Healthcare Professional

Health Care Professional Recommendation
(Physician, Nurse Practitioner, Physician's Assistant)

Child's Name:_____ Date of Birth:_____ Age: _____

Parent/Guardian's Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Fax:_____ Email:_____

To be completed by the child's primary health care professional.

Name of Health Care Professional: _____

Name of Practice: _____

Address:_____ City:_____ Zip: _____

Phone:_____ Pager:_____ Fax: _____

Email: _____

Childcare regulations requires that child care facilities place all infants on their backs to sleep. At the advice of the infant's primary health care professional, the facility may be authorized to use an alternative sleep position for the infant for medical reasons.

The infant named above has the following medical condition, which necessitates an alternative sleep position: _____

_____

The appropriate sleep position for the infant named above is: _____

Effective Dates of Waiver: from_____/_____/_____to_____/_____/ _____

Health Care Professional's Signature _____ **Date**_____

"I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that I been provided with information concerning SIDS. I further authorize the child care facility and its employees to place my child in an alternative sleep position, at the recommendation of my child's primary health care professional, as described above."

Parent/Guardian Signature:_____ Date: _____

An authorized official with the child care facility must complete the following section.

Name of Child Care Facility:_____ ID #:_____

Facility Representative's Signature:_____ Date: _____