Alternative Sleep Position Waiver

Parent Request*

Parent Request

This waiver may ONLY be used for infants over the age of 6 months.

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

Parent/Guardian's Name: _____

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

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

Fax:_____ Email:_____

This child care facility follows the safe sleep practice of placing all infants on their backs to sleep. As the parent or guardian Of the above named child, you may request that he/she be placed in an alternative sleep position.

Check the box below for this waiver to be valid:

☐ **I would like my child placed to sleep in an alternative sleep position.**

Please describe the requested sleep position for the above named child:

_____

_____

_____

Effective Dates of Waiver: From_____/_____/_____ to_____/_____/_____

"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, 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: _____