

Alternative Sleep Position Waiver

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



Parent/guardian completes this section.

Child's name _____ Date of birth _____ Age in months _____

Parent/guardian name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email _____

Child's primary health care professional completes this section.

Health care professional's name _____

Name of practice _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell or Pager _____ Fax number _____

Email _____

Child Care Law 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 parent/guardian may authorize the facility to place their infant in an alternative sleep position for medical reasons. **The center shall retain the waiver in the child's record as long as the child is enrolled at the center.**

Medical reason for alternative sleep position for infant named above _____

The recommended sleep position for this infant is _____

Effective Dates of Waiver: from ____/____/____ to ____/____/____

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

Parent/guardian signs this statement.

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 the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position described above at the recommendation of my child's primary health care professional.

Parent/guardian signature _____ **Date** _____

An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility _____ ID # _____

Facility Representative's Signature _____ **Date** _____