Alternative Sleep Position

Child's Full Name: _____ **Date of Birth:** ____/____/____

Parent/Guardian's Full Name: _____

Address: _____

Phone: _____ **Email:** _____

Michigan State Licensing Rules State the following:

Documentation from the child's health care provider is required if a child has a health issue or special need that requires the child to sleep in something other than a crib or porta-crib for infants or toddlers, or cot or mat for toddlers. ***The documentation must include specific sleeping instructions and time frames for how long the child needs to sleep in this manner, including an end date.***

Paradigm Care & Enrichment Center 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 to sleep in an alternative sleep position with a physician's written instructions

PARENT/ GUARDIAN PERMISSION

I, _____ as the parent or guardian of , _____, do
PARENT/ GUARDIAN FULL NAME CHILD'S FULL NAME

hereby release and hold harmless Paradigm Care & Enrichment Center, its officers, directors, and employees, from any and all liability whatsoever associated with harm to the above named child, due to Sudden Infant Death Syndrome (SIDS). We do not hold Paradigm Care & Enrichment Center or Staff members of Paradigm Care & Enrichment Center liable for possible complications, including death, associated with placing the above named child, in an alternative sleep position, as described by a doctor above or in the alternate sleep equipment written above by the physician. I understand information concerning SIDS. I understand that the American Academy of Pediatrics supports the "Back to Sleep Campaign." The "Back to Sleep Campaign" states that: I am aware that placing babies on their backs to sleep reduces the risk of Sudden Infant Death Syndrome also known as SIDS or Crib Death.

_____ _____ _____

PARENT/ GUARDIAN PRINT NAME ***PARENT/ GUARDIAN SIGNATURE*** ***DATE***

PEDIATRICIAN PERMISSION

As the treating Pediatrician of the above named child, I give written permission for alternative sleep positions/ sleep equipment other than sleeping on his/her back in a crib without any objects. I have described the requested sleep position, including time frame(s) for how long they need to sleep in this manner, for the above name child below:

_____

_____

_____

Permission effective from ____/____/_____ ***to*** ____/____/_____

_____ _____

PEDIATRICIAN SIGNATURE ***DATE***

PHYSICIAN'S OFFICE STAMP
(Required for authenticity)