ITS-SIDS Alternative Sleep Position Parent Waiver

Parents may only use this waiver for infants over the age of 6 months.

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 _____

The child care facility named below places all infants on their backs to sleep to reduce the risk of Sudden Infant Death Syndrome (SIDS). As the parent or guardian of the child named above I request that the child be placed to sleep in an alternative sleep position now that my child is 6 months or older. The facility shall retain the waiver in the child's record as long as the child is enrolled at the center.

This waiver is valid if I have checked the box below.

☐ I request that my child not be placed on the back to sleep and instead placed to sleep in the alternative sleep position described below.

I request that the child care facility place my child in the alternative sleep position described below.

_____

_____

_____

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 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 my request.

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 _____

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu